Supreme Court, U. S.
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In the
Supreme Court of the United States.

OCTOBER TERM, 1978.

No. **78-378**

ST. ELIZABETH'S HOSPITAL OF BOSTON,
PETITIONER,

v.

STEPHEN M. WEINER, INDIVIDUALLY AND AS HE IS CHAIRMAN OF THE RATE SETTING COMMISSION IN THE EXECUTIVE OFFICE OF HUMAN SERVICES IN THE EXECUTIVE DEPARTMENT FOR THE COMMONWEALTH OF MASSACHUSETTS, ET AL.,
RESPONDENTS.

Petition for a Writ of Certiorari to the United States Court of Appeals for the First Circuit.

WILSON D. ROGERS, JR.,
CHARLES J. DUNN,
27 School Street,
Boston, Massachusetts 02108.
(617) 523-2950

BATEMAN & SLADE, INC. BOSTON, MASSACHUSETTS.

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RESPONDENTS.

Petition for a Writ of Certiorari to the United States Court of Appeals for the First Circuit.

The petitioner prays that a writ of certiorari issue to review the memorandum and order of the United States Court of Appeals for the First Circuit entered in the above case on June 7, 1978.

Opinions Below.

The order of the District Court for the District of Massachusetts is unreported. This order of the District Court incorporates by reference an earlier opinion of the District Court for the District of Massachusetts which is also unreported. The memorandum and order of the Court of Appeals for the First Circuit is likewise unreported, and incorporates by reference an earlier decision of the Court of Appeals for the First Circuit reported at 569 F. 2d 1156. Copies of the aforementioned orders and the memorandum and order are appended to this petition in the appendix at pages 1a-5a, 10a-24a.

Jurisdiction.

The memorandum and order of the Court of Appeals for the First Circuit was made and entered on June 7, 1978 (A. 12a-13a). The memorandum and order incorporates by reference an opinion of the Court of Appeals for the First Circuit made and entered on January 25, 1978, in the case of *Massachusetts General Hospital* v. *Stephen M. Weiner et al.* (A. 14a-24a). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

Questions Presented.

In a civil action initially brought pursuant to 28 U.S.C. §§ 1331(2) and 1343(3) and (4), the petitioner sought declaratory and certain injunctive relief from Medicaid rate regula-

tions promulgated by the Rate Setting Commission of the Commonwealth of Massachusetts and subsequently approved by the Secretary of Health, Education and Welfare, which rate regulations were then incorporated in the medical assistance (Medicaid) program for the Commonwealth of Massachusetts. The regulations in question are RSC Regs. 74-1, 74-26, and 14 CHSR 3, which establish a prospective rate setting system of reimbursing hospitals for providing inpatient services to Medicaid-eligible patients. The petitioner filed a motion for summary judgment (A. 6a) on the basis, inter alia, that 42 U.S.C. § 1396a(a)(13)(D) requires reimbursement of the petitioner for its reasonable costs of furnishing inpatient services to Medicaid beneficiaries. The respondents filed cross-motions for summary judgment (A. 10a). The District Court granted the respondents' cross-motions for summary judgment (A. 10a-11a). The Court of Appeals affirmed. The questions presented are:

1. Whether the petitioner's costs for treating Medicaid patients are its reasonable costs under 42 U.S.C. § 1396(a)(13)(D) when it is providing efficient, necessary, high-quality care to eligible Medicaid beneficiaries.

2. Whether Congress gave the respondent Secretary of Health, Education and Welfare authority to approve a prospective rate setting system on a state-wide basis.

3. Whether the respondent Secretary of Health, Education and Welfare erred in approving the Massachusetts Medicaid system.

4. Whether the Massachusetts Medicaid reimbursement system unconstitutionally deprives the petitioner of due process of law as required by the Fourteenth Amendment to the United States Constitution.

5. Whether the Court of Appeals erred in affirming the action of the District Court in ruling that the Massachusetts Medicaid reimbursement system provides the petitioner rea-

sonable cost reimbursement as required by 42 U.S.C. § 1396a (a)(13)(D) for treating eligible Medicaid patients.

6. Whether the Court of Appeals erred in affirming the action of the District Court in granting cross-motions for summary judgment by the respondents under Rule 56 of the Federal Rules of Civil Procedure.

Constitutional Provisions, Statutes and Regulations Involved.

UNITED STATES CONSTITUTION.

Fourteenth Amendment.

SECTION 1.

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

. . . . . .

UNITED STATES CODE, TITLE 42.

§ 1396a. [State plans for medical assistance — Contents.]

(a) A State plan for medical assistance must —

. . . . . .

(13) provide —

. . . . . .

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1320a-1 of this title, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1395x(v) of this title as the reasonable cost of such services for the purposes of subchapter XVIII of this chapter . . ..

. . . . . .

PUBLIC LAW 92-603 — OCTOBER 30, 1972.

DETERMINATION OF REASONABLE COST OF INPATIENT HOSPITAL SERVICES UNDER MEDICAID AND UNDER MATERNAL AND CHILD HEALTH PROGRAM.

SEC. 232. (a) Section 1902(a)(13)(D) of the Social Security Act is amended to read as follows:

"(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII;".

Rate Setting Commission Regulations 74-1, 74-26, and 14 CHSR 3 are set forth in the appendix at pages 25a-123a.

Statement of the Case.

The Massachusetts General Hospital, in Boston, Massachusetts, initially brought a civil action pursuant to 28 U.S.C. §§ 1331(a) and 1343(3) and (4), seeking declaratory and injunctive relief from Medicaid rate regulations promulgated by the Rate Setting Commission of the Commonwealth of Massachusetts and later approved by the Secretary of Health, Education and Welfare, which rate regulations were then incorporated in the medical assistance (Medicaid) program for the Commonwealth of Massachusetts. The defendants in this action were:

> The Rate Setting Commission of the Commonwealth of Massachusetts;
>
> The Commissioner of the Department of Public Welfare in the Executive Office of Human Services in the Executive Department of the Commonwealth of Massachusetts;
>
> The Secretary of the Office of Human Services in the Executive Department of the Commonwealth of Massachusetts;
>
> The Governor of the Commonwealth of Massachusetts; and
>
> The Secretary of the United States Department of Health, Education and Welfare.

The federal defendant filed an answer to the complaint of the Massachusetts General Hospital ("MGH") on September 16,

1975. On March 22, 1976, the state defendants filed a motion to dismiss. On April 15, 1976, the petitioner, St. Elizabeth's Hospital of Boston ("St. Elizabeth's"), filed a motion to intervene in this action as a party plaintiff, together with a complaint as intervening party plaintiff. On April 16, 1976, the District Court heard arguments on defendants' motion to dismiss and took the matter under advisement. Subsequently the defendants and the plaintiff MGH filed cross-motions for summary judgment.

On January 24, 1977, the aforementioned cross-motions for summary judgment were heard in oral argument by the District Court and taken under advisement. On January 24, 1977, at the time of oral argument on the cross-motions for summary judgment of the defendants and the plaintiff MGH, the District Court, in the absence of any objection, allowed the motion of the petitioner, St. Elizabeth's, to intervene. On February 4, 1977, the District Court ordered summary judgment for the defendants (A. 1a-5a). On May 16, 1977, the District Court, after hearing, determined that the petitioner was not bound by the District Court's order of February 4, 1977, granting the defendants' motion for summary judgment. On May 31, 1977, St. Elizabeth's filed a motion for summary judgment (A. 6a), together with an affidavit of Charles J. Jacobs, Associate Director for Fiscal Services at St. Elizabeth's (A. 7a-10a), together with other supporting exhibits. On June 7, 1977, the federal defendant filed a memorandum in support of a motion for summary judgment and in opposition to the petitioner's motion for summary judgment. On June 8, 1977, the state defendants filed a motion for summary judgment.

On June 23, 1977, the District Court granted summary judgment to the defendants and denied the petitioner's motion for summary judgment (A. 10a-11a). In so doing, the District Court incorporated as grounds for its order of June 23, 1977,

the grounds set forth in the District Court's above-mentioned order of February 4, 1977 (A. 1a-5a), granting the defendants' motion for summary judgment as to the plaintiff MGH. Both the petitioner and the plaintiff MGH appealed the action of the District Court to the Court of Appeals for the First Circuit. These appeals were heard separately by the Court of Appeals, with the oral argument in the MGH appeal occurring first. When oral argument took place in the petitioner's appeal, the MGH appeal was still under advisement by the Court of Appeals. On January 25, 1978, the appellate court entered an opinion in the case of *Massachusetts General Hospital* v. *Weiner et al*, reported at 569 F. 2d 1156 (A. 14a-24a). On June 7, 1978, the First Circuit Court of Appeals entered a memorandum and order in the appeal of the petitioner, affirming the action of the District Court and incorporating by reference its earlier opinion (A. 12a-13a).

Reasons for Granting the Writ.

The decision below should be reviewed because it erroneously interprets 42 U.S.C. § 1396a(a)(13)(D) in contravention of the intent of the United States Congress. The decision below permits prospective rate setting mechanisms, pursuant to which participating providers may be reimbursed less than their actual costs of furnishing inpatient care to Medicaid beneficiaries, even when such care is quality and necessary care furnished on an efficient and economic basis. Given the magnitude of the Medicaid program, the issues in this case are of far-reaching importance and should be addressed by this Court in order to resolve the concept of "reasonable costs" within the context of reimbursement mechanisms pursuant to 42 U.S.C. § 1396a(a)(13)(D).

As already noted, the petitioner filed a motion for summary judgment which was denied by the District Court and which denial was affirmed by the Court of Appeals for the First Circuit. In support of this motion for summary judgment, the petitioner filed an affidavit of Charles J. Jacobs, Associate Director of Fiscal Services at the petitioner hospital (which affidavit is hereinafter referred to as the "Jacobs affidavit") (A. 7a-10a). In addition to denying the petitioner's motion for summary judgment, the District Court granted the respondents' cross-motions for summary judgment (A. 10a-11a). In accordance with the provisions of Rule 56(c) of the Federal Rules of Civil Procedure, summary judgment may be entered "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Thus, the District Court, in denying the petitioner's motion for summary judgment and in granting the cross-motions of the respondents for summary judgment, found all of the material facts referenced in the Jacobs affidavit as true, otherwise summary judgment could not, in accordance with Rule 56(c), have been granted.

Prior to Public Law 92-603, Medicaid rates of reimbursement to participating providers were determined in accordance with Medicare principles. A legislative determination was made, however, that Medicare and Medicaid patient populations were sufficiently different so that some provider hospitals were being reimbursed in excess of actual costs for treating Medicaid patients. Accordingly, P.L. 92-603 was enacted. Section 232 of P.L. 92-603 amended 42 U.S.C. § 1396a(a)(13)(D), according states some flexibility in developing methods and standards for determining the reasonable cost of inpatient hospital services for Medicaid patients. As amended by P.L. 92-603, 42 U.S.C. § 1396a(a)(13)

(D) requires that the state plan for medical assistance provide for payment of the reasonable cost of inpatient services provided under the plan with the added caveat that, in no event, may this reasonable cost exceed the amount determined under Title XVIII (Medicare).

The Massachusetts state plan, as approved by the respondent Secretary of Health, Education and Welfare, establishes a prospective rate setting system in the Commonwealth of Massachusetts, pursuant to which plan the respondent Rate Setting Commission has promulgated certain regulations. Under these regulations and pursuant to the state plan, a participating hospital's costs of providing inpatient services to all patients for a set period of time are determined (which period is referred to as the base year). This calculation yields an average cost for all patients, to which is added an inflation factor, resulting in a prospective, per-diem rate for Medicaid beneficiaries.

In the first instance, the respondent Secretary of H.E.W. erred in approving the state plan. In its present form, this plan contravenes existing, authorizing federal legislation. Public Law 92-603, and more specifically § 222, authorizes the respondent Secretary of H.E.W. to carry out experiments and demonstration projects to determine the relative advantages and disadvantages of prospective reimbursement mechanisms. Subsection 2 of P.L. 92-603, § 222, has a caveat, however, that these experiments and demonstration projects shall not commit these programs to the adoption of any prospective payment system, locally or nationally.[1]

It is clear, therefore, that the respondent Secretary of H.E.W. had no authority to approve a prospective reimbursement system on a state-wide basis.

[1]Section 232 broadly authorizes "alternative programs." Section 222, however, specifically limits "prospective" mechanisms.

More importantly, however, as applied to the petitioner, St. Elizabeth's, this prospective system does not reimburse the hospital for its reasonable costs of furnishing inpatient services, provided "under the plan," as required by 42 U.S.C. § 1396a(a)(13)(D). As already noted, this prospective rate system produces or results in a rate which is an average rate: based upon the costs of furnishing inpatient care to *all patients*, not just Title XIX (Medicaid) patients. In the case of the petitioner, it has experienced and continues to experience a greater intensity in utilization of services by Title XIX or Medicaid patients (see paragraph 11 of Jacobs affidavit, A. 8a). Consequently, St. Elizabeth's is being reimbursed under this prospective rate system for less than its actual cost of furnishing inpatient care to Title XIX beneficiaries (see paragraphs 14 and 15 of Jacobs affidavit, A. 9a).

To demonstrate the magnitude of this problem, the petitioner has calculated that, for the six-month period October 1, 1974, to April 30, 1975, it was, under the current prospective rate system, reimbursed $165,000 less than its actual cost of furnishing services to Title XIX (Medicaid) beneficiaries (see paragraph 9 of Jacobs affidavit, A. 8a). The District Court found that the petitioner furnishes quality and necessary inpatient care to Title XIX (Medicaid) beneficiaries on an efficient and economic basis (see paragraphs 5 and 6 of Jacobs affidavit, A. 7a-8a). To the extent that the petitioner, St. Elizabeth's, is not being reimbursed for its actual cost of furnishing quality and necessary inpatient care to Title XIX (Medicaid) beneficiaries on an efficient and economic basis, it is not being reimbursed for its "reasonable costs" as required by 42 U.S.C. § 1396a(a)(13)(D). While such cases as *Connecticut State Department of Public Welfare* v. *Department of Health, Education and Welfare*, 448 F. 2d 209 (2d Cir. 1971), and *Catholic Medical Center of Brooklyn & Queens, Inc.* v. *Rockefeller*, 305 F. Supp. 1256 (E.D. N.Y. 1969), predate

P.L. 92-603 and its amendatory impact on the Medicaid or Title XIX system of reimbursement, the change wrought by P.L. 92-603 accords some flexibility in determining reasonable costs, yet does not change the concept of "reasonable costs." The concept of reasonable costs in this regard has obtained for a substantial period of time. Congress was certainly conversant with this concept and could have modified it, but chose not to do so. Of substantial import here is the effect of a prospective reimbursement mechanism, pursuant to which the petitioner, St. Elizabeth's, is being reimbursed less than its actual cost of furnishing quality and necessary inpatient care to Title XIX (Medicaid) beneficiaries on an efficient and economic basis. The effect in this instance is one of cost shifting. *Humana of South Carolina, Inc.* v. *Mathews*, 419 F. Supp. 253 (D. D.C. 1976).

To the extent that non-Medicaid patients must meet these unreimbursed costs, there is a prima facie showing of cost shifting. 42 U.S.C. § 1396a(a)(13)(D) requires payment to a provider of the reasonable cost of inpatient hospital services "under the plan." Clearly, on its face, this authorizing legislation does not encompass cost shifting.[2]

Not only is the current prospective reimbursement mechanism in the Commonwealth of Massachusetts, hereinabove referred to, in contravention of authorizing federal legislation, but the financial impact of such a system can be devastating upon the overall Medicaid system. The questions presented by this case, therefore, are of great and recurring significance in the administration of the Title XIX (Medicaid)

[2]The legislative history, with respect to amendments to the Social Security Act, H.R. Rep No. 92-121, reproduced in the U.S. Code Cong. & Admin. News, 92d Cong., 2d Sess., pages 4989, 5087, states that the methods adopted by the states should not be used as a device for shifting costs from Medicaid to non-Medicaid recipients.

system. The questions raised here and the effect of the decision below, if unreversed, upon the future of the health care system in this country make this case a particularly appropriate one for the exercise of this Court's discretionary jurisdiction.

Conclusion.

For the reasons set forth above, it is respectfully submitted that this petition for a writ of certiorari should be granted.

Respectfully submitted,

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Counsel for Petitioner.

Appendix A.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

MASSACHUSETTS GENERAL HOSPITAL,
PLAINTIFF,

v.

CIVIL ACTION
No. 75-2651-G

STEPHEN M. WEINER ET AL.,
DEFENDANTS.

Order Granting Defendants' Motions for Summary Judgment.

February 4, 1977.

GARRITY, J. At hearings on April 16, 1976 and January 24, 1977, all parties were heard extensively after submission of lengthy briefs and supporting documents and affidavits on the issues of state, federal and constitutional law raised in this case. Prior to the January 24 hearing, all parties filed cross-motions for summary judgment. Thus the case is ripe for summary disposition under Rule 56, Fed. R. Civ. P.

At issue is whether a plan of prospective reimbursement ("the plan") for paying the cost of inpatient hospital services provided to Massachusetts Medicaid patients, developed by the Commonwealth of Massachusetts and approved by the Secretary of Health, Education and Welfare (HEW), meets the "reasonable cost" requirement of 42 U.S.C. § 1396(a)(13)(D) and the implementing federal regulation at 45 C.F.R. 250.30; whether the prospective reimbursement plan con-

forms to various procedural requirements of state law found in Mass. G.L. c. 6A, §§ 32, 36, and Mass. G.L. c. 30A, §§ 1, 2; finally, whether the prospective reimbursement plan protects the plaintiff's constitutional rights under art. I, § 10, cl. 1 of the United States Constitution and its rights of equal protection and due process of law under the Fourteenth Amendment to the Constitution.

Preliminarily, we find that this case raises no genuine issue as to any material fact. Turning then to the issues of law raised by the plaintiff, we find each of its claims to be without merit and grant, therefore, the defendants' motions for summary judgment.

1. *Reasonable cost.* Plaintiff claims that the plan developed by the Rate Setting Commission of the Commonwealth of Massachusetts and approved by the Secretary of HEW violates the provision of 42 U.S.C. § 1396(a)(13)(D) which requires that a state plan must provide "for payment of the reasonable cost of inpatient hospital services." Although plaintiff decries several features of the plan, it objects principally to the fact that reimbursement under the extremely complex state scheme is based initially on the average cost of all inpatients per day in a given hospital rather than on the average cost of all Medicaid patients per day. As applied to it, at least, plaintiff contends that this feature of the plan deprives it of its reasonable cost, since it presently experiences substantially higher actual average daily costs for Medicaid patients than it does for non-Medicaid patients. Plaintiff also notes that other hospitals under the plan experience average costs for Medicaid patients substantially lower than average costs for other patients. Clearly, then, the plan is not pegged with precise accuracy to the actual average cost of Medicaid patients in each

hospital which participates in the plan. And there are other aspects of the plan which might also be shown to operate imprecisely in the case of a particular hospital.

But the issue of law is not whether the plan is perfect but rather whether, under a complex system of reimbursement which has among other objectives the admittedly valid goal of providing "incentives for efficiency and economy", 45 C.F.R. 250.30, the plan can be said to provide for "payment of the reasonable cost of inpatient hospital services."

By approving the plan, the Secretary of HEW concluded that the plan, taken as a whole, does provide for payment of reasonable cost. Important in his determination was the fact that the plan provides for rate adjustments and an appeal mechanism.

We believe that the memoranda filed by the Secretary of HEW offer ample support for his judgment that the plan should be approved. See federal defendant's memorandum filed April 13, 1976, at 10-15, and additional memorandum filed January 24, 1977, at 2-3. And we believe that his informed judgment is entitled to considerable deference from this court. See *Mourning* v. *Family Publications Service, Inc.*, 1973, 411 U.S. 356, 371-373; *Knebel* v. *Hein*, 1977, 45 U.S.L.W. 4083, 4085. Based on an analysis of the plan and the filings in support of it by the Secretary, we conclude that although reasonable minds might differ over the wisdom of various features of the plan, that taken as a whole, it is neither arbitrary nor capricious and clearly satisfies the reasonable cost requirement of 42 U.S.C. § 1396(a)(13)(D).

2. *State law.* Plaintiff claims that the Rate Setting Commission has violated state law, specifically Mass. G.L. c. 6A, §§ 32, 36 and Mass. G.L. c. 30A, §§ 1, 2, by setting actual dollar and cents rates for the plaintiff under the prospective

rate system without affording him a prior opportunity to be heard.[1]

Plaintiff misses a critical distinction, clearly recognized in Massachusetts case law, between regulations of general application, which must be preceded by hearing under Mass. G.L. c. 30A, § 1 and, for health care statutes, under Mass. G.L. c. 6A, § 32; and specific applications of those general regulations, for which no prior hearing appears to be required. See *Haverhill Manor, Inc.* v. *Commissioner of Public Welfare*, 1975, Mass. Adv. Sh. 1813, 1820. We find the plaintiff's statutory claims to be without merit.

3. *Constitutional claims.*

a. *Due process.* Plaintiff claims that application of the Massachusetts statutory rate setting process deprives it of due process of law under the Fourteenth Amendment to the Constitution. "Due process" is a flexible concept, the requirements for which vary according to the particular circumstances involved. *Cafeteria & Restaurant Workers* v. *McElroy*, 1961, 367 U.S. 893, 895. We find that the Massachusetts prospective rate system as applied to plaintiff affords it adequate opportunity to be heard and to contest the rates set for its services, consistently with standards articulated in *McElroy* and refined in subsequent decisions. See *McElroy, supra*; *Mitchell* v. *W.T. Grant Co.*, 1974, 416 U.S. 600, 611.

b. *Equal protection.* Plaintiff claims that the Rate Setting Commission, by establishing rates for other health care facilities different from those applied to it, has denied it equal protection of the law. In the area of social welfare, the traditional equal protection test is applicable, requiring only that

[1] Plaintiff acknowledges that public hearings were held before the prospective rate system itself was implemented.

the legislative classification to be valid have some "reasonable basis", *Dandridge* v. *Williams*, 1970, 397 U.S. 471, 485, or that it be "rationally related to a legitimate government interest." *United States Dept. of Agriculture* v. *Moreno*, 1973, 413 U.S. 528, 533. We find that the lines drawn by the state in its health care reimbursement regulations are clearly rational. Among other relevant distinctions, hospitals provide fundamentally different and far more comprehensive care than do, for example, nursing homes. See state defendants' memorandum, filed March 22, 1976, at 14-15.

c. *Contract impairment.* Plaintiff finally claims that defendants' actions have interfered with its contract rights by preventing reimbursement of reasonable cost for services rendered, thus violating the impairment clause of the United States Constitution, art. I, § 10, cl. 1. Before plaintiff can claim impairment, it must have a vested contractual right. But when the plaintiff enters into its annual agreement with the Commonwealth, it is fully aware that under Mass. G.L. c. 6A, § 35, it must accept reimbursement at rates which will be subsequently established by the Rate Setting Commission. Plaintiff's impairment argument is therefore also denied.

Having found that there are no genuine issues of material fact and resolved all issues of law against the plaintiffs, summary judgment of dismissal will enter for the defendants in this case.

W. ARTHUR GARRITY, JR.,
United States District Judge.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

MASSACHUSETTS GENERAL HOSPITAL,

v.

CIVIL ACTION
No. 75-2651-G

STEPHEN M. WEINER ET AL.,

Motion for Summary Judgment.

1. Now comes the Plaintiff Intervenor, St. Elizabeth's Hospital of Boston, in the above-captioned matter and respectfully moves that this Honorable Court enter a Summary Judgment in its behalf for the relief requested in Plaintiff Intervenor's Complaint in accordance with Rule 56 of the Federal Rules of Civil Procedure.

2. The Plaintiff Intervenor submits that there is no genuine issue as to any material fact and that Plaintiff Intervenor is entitled to judgment as a matter of law.

3. This Motion is based upon

a) All the pleadings;

b) Affidavit of Charles J. Jacobs filed herewith;

c) Exhibits in support of this Motion For Summary Judgment submitted herewith.

Respectfully submitted,
ST. ELIZABETH'S HOSPITAL
OF BOSTON,
By Its Attorney,
WILSON D. ROGERS, JR.,

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

MASSACHUSETTS GENERAL HOSPITAL,

vs.

CIVIL ACTION
No. 75-2651-G

STEPHEN M. WEINER ET AL.,

Affidavit.

I, Charles J. Jacobs of Quincy, Massachusetts, am the Associate Director for Fiscal Services at St. Elizabeth's Hospital of Boston, with overall responsibility and supervision of the financial operation of the Hospital. I am familiar with the Complaint of St. Elizabeth's Hospital of Boston in this action and state under oath as follows:

1. I adopt Exhibits 1 through 17 submitted with the Plaintiff Intervenor, St. Elizabeth's Hospital of Boston's, Motion for Summary Judgment in this action.

2. St. Elizabeth's Hospital of Boston is a duly organized Massachusetts, non-profit corporation with a usual place of business at 736 Cambridge Street, Brighton, Massachusetts.

3. St. Elizabeth's Hospital of Boston is licensed by the Department of Public Health in the Commonwealth of Massachusetts as an acute care, general Hospital.

4. St. Elizabeth's Hospital of Boston is a participant in the Title XIX Medicaid program.

5. St. Elizabeth's Hospital of Boston furnishes quality and necessary inpatient and outpatient hospital care to Title XIX patients.

6. St. Elizabeth's Hospital of Boston in furnishing quality and necessary care to Title XIX patients, does so on an efficient and economic basis.

7. St. Elizabeth's Hospital of Boston in furnishing hospital care to Title XIX patients furnishes only such care as is necessary in accordance with good and accepted standards of medical care.

8. St. Elizabeth's Hospital of Boston, as a result of rates of reimbursement set for it by the Commonwealth of Massachusetts through the Rate Setting Commission, is incurring financial loss. Said loss is as a direct result of said reimbursement rates being less than the current reasonable cost of care of Title XIX beneficiaries at St. Elizabeth's Hospital of Boston at the time said services are being rendered and the rates being paid.

9. The losses aforesaid sustained by the Hospital amount to more than $165,000.00 for the period October 1, 1974, through April 30, 1975, and more than $47,000.00 for the period October 1, 1973, through March 31, 1974.

10. St. Elizabeth's Hospital of Boston has incurred and will incur losses in each fiscal year in the future as a result of the present State Rate Setting Commission Regulations used for reimbursement of care furnished Title XIX beneficiaries.

11. It costs more to furnish care for Title XIX patients at St. Elizabeth's Hospital of Boston than for the average patient due to more intensive use of services by Title XIX beneficiaries.

12. St. Elizabeth's Hospital of Boston has participated and continues to participate in the Title XIX Medicaid Program, with the understanding that it would receive its reasonable cost reimbursement for the care it furnishes to Title XIX beneficiaries.

13. In fiscal years 1974 and 1975, St. Elizabeth's Hospital of Boston was reimbursed less than its reasonable cost of furnishing care to Title XIX beneficiaries. (See Exhibit 13)

14. The use of an average per diem rate (RSC Regulation 74-1 and RSC Regulation 74-26) based on the reasonable cost of care of all patients from two years prior for the then current care of Title XIX beneficiaries, results in a reimbursement rate that is below the cost of such care to the Hospital. The Hospital thereby receives less than its reasonable cost of care for Title XIX beneficiaries.

15. Under 14 CHSR 3 (See Exhibit 12) the Rate Setting Commission has undertaken to set and establish a Medicaid rate of reimbursement for St. Elizabeth's Hospital of Boston for fiscal year 1977. In so doing, and in accordance with said Regulation, it certifies and establishes the cost of care to all patients (not just Title XIX patients) for fiscal year 1975. An arbitrary inflation factor is then applied in order to arrive at a per diem rate of reimbursement for Title XIX patients for fiscal year 1977. The Rate Setting Commission, before the addition of the inflation factor, has for fiscal 1975 arrived at a per diem cost of $173.79 per day. This cost is more than $18.00 a day higher than the per diem reimbursement to St. Elizabeth's Hospital of Boston in fiscal 1975. The Rate Setting Commission, therefore, notwithstanding its mandate to reimburse a Hospital its reasonable cost of furnishing care to Title XIX beneficiaries, reimbursed St. Elizabeth's Hospital of Boston in fiscal 1975 more than $18.00 per day less than the reasonable cost of furnishing such care to all patients during that period of time as subsequently established and certified by the Rate Setting Commission.

16. It is my opinion that unless St. Elizabeth's Hospital of Boston is reimbursed its reasonable costs for each Title XIX patient, the costs of the care of such patient must be borne by other patients of the Hopsital.

CHARLES J. JACOBS,
Associate Director for
Fiscal Services.

Then appeared before me on the 31st day of May, 1977, the aforementioned, Charles J. Jacobs, and swore that the information contained in this Affidavit and the Exhibits referred to herein are true to the best of his knowledge and belief.

EDWARD T. HUGHES,
Notary Public.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

MASSACHUSETTS GENERAL HOSPITAL,
PLAINTIFF,

v.

CIVIL ACTION
No. 75-2651-G

STEPHEN M. WEINER ET AL.,
DEFENDANTS.

Summary Judgment for Defendants on Complaint of Plaintiff-Intervenor

June 23, 1977.

GARRITY, J. Upon consideration of the motion by St. Elizabeth's Hospital of Boston, plaintiff-intervenor, filed May 31, 1977, for summary judgment and supporting affidavit and exhibits, and of cross-motions for summary judgment by the state and federal defendants and supporting materials, it is ordered that the plaintiff-intervenor's motion be denied and

the defendants' be allowed and that judgment be entered dismissing the plaintiff-intervenor's complaint.

This order is entered without hearing the cross-motion because upon consideration of the materials described in the previous paragraph it is clear that the plaintiff-intervenor's complaint raises no issues other than those already fully briefed, argued and decided by the court's order entered February 4, 1977. The claims of the plaintiff-intervenor are rejected (on the same grounds heretofore stated). No purpose would be served by a further hearing. Also the appeal of the original plaintiff, Massachusetts General Hospital, is being delayed pending resolution of the plaintiff-intervenor's claims, which should therefore be ruled upon as expeditiously as circumstances permit.

W. ARTHUR GARRITY, JR.,
United States District Judge.

Appendix B.

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 77-1364.

MASSACHUSETTS GENERAL HOSPITAL,
PLAINTIFF, APPELLEE,

v.

STEPHEN M. WEINER ET AL.,
DEFENDANTS, APPELLEES,

ST. ELIZABETH'S HOSPITAL OF BOSTON,
PLAINTIFF, INTERVENOR, APPELLANT.

Memorandum and Order.

Entered June 7, 1978.

At oral argument, plaintiff-intervenor-appellant St. Elizabeth's Hospital of Boston represented that contentions in this appeal are the same as those of plaintiff-appellant Massachusetts General Hospital in *Massachusetts General Hospital* v. *Weiner*, 569 F.2d 1156 (1st Cir. 1978). Our independent review of the record confirms that to be the case.

Our opinion in *Massachusetts General Hospital* v. *Weiner*, issued on January 25, 1978, resolved all claims against appellant in that case. The summary judgment of dismissal against

plaintiff-intervenor-appellant St. Elizabeth's Hospital of Boston is therefore affirmed.

By the Court:

/s/ DANA H. GALLUP,
Clerk.

United States Court of Appeals
For the First Circuit

No. 77-1191

MASSACHUSETTS GENERAL HOSPITAL,

PLAINTIFF, APPELLANT,

v.

STEPHEN M. WEINER, ET AL.,

DEFENDANTS, APPELLEES.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS
[HON. W. ARTHUR GARRITY, JR., *U.S. District Judge*]

Before:
COFFIN, *Chief Judge*
CAMPBELL, *Circuit Judge*
CRARY, *District Judge*•

H. Scott Haskell, with whom *Albert G. Tierney, Jr.* and *Tierney, St. Onge & Manoil* were on brief, for appellant.
S. Stephen Rosenfeld, Assistant Attorney General, with whom *Francis X. Bellotti,* Attorney General, was on brief, for Stephen M. Weiner et al., appellees.
William A. Brown, Assistant United States Attorney, Chief, Civil Division, with whom *Edward F. Harrington,* United States Attorney, and *Nancy S. Nemon,* Deputy Regional Attorney, Department of Health, Education, and Welfare, were on brief, for Joseph A. Califano, Jr.

January 25, 1978

CRARY, *District Judge.* This appeal is from an order of the District Court granting the appellees' motion for summary judgment in an action filed by the Massachusetts General Hospital (MGH) in July, 1975, seeking declaratory

• Of the Central District of California, sitting by designation.

and injunctive relief from Medicaid rate regulations promulgated by the Massachusetts Rate Setting Commission (the Commission) and approved by the Secretary of Health, Education and Welfare (the Secretary), pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396a(a)(13)(D).

At issue is (1) whether a plan of prospective reimbursement ("the Plan") for paying the cost of inpatient hospital services provided to Massachusetts Medicaid patients, developed by the State of Massachusetts and approved by the Secretary, meets the "reasonable cost" requirement of 42 U.S.C. § 1396a(a)(13)(D), and implementing Federal regulation at 45 C.F.R. 250.30, (2) whether the prospective reimbursement plan conforms to various procedural requirements of the State law of Massachusetts, and (3) whether the prospective reimbursement plan protects the appellant's constitutional rights under Article I, Section 10, Clause 1, of the United States Constitution, and its rights of equal protection and due process of law under the 14th Amendment to the Constitution.

Appellant and State appellees filed cross motions for summary judgment and, on February 4, 1977, the District Court, in a well-reasoned order, granted the State appellees' motion on the grounds there was no genuine issue of material fact and all issues of law were decided in favor of the State defendants, appellees herein.

The prospective rate system proposed by Massachusetts and approved by the Secretary, and subsequently included in its Title XIX State Plan, provides for all inpatient hospital care for Medicaid patients to be reimbursed by an all-inclusive per diem payment. State regulations 74-1, 74-26 and 14 C.H.S.R. 3, set forth the formula by which rates of reimbursement for hospitals participating in the Medicaid program were to be calculated. Under this formula the Medicaid rate, which was prospective in nature

for a hospital, was established by dividing its base year[1] costs for *all* inpatients by its allowed number of the base year inpatient days. An inflation factor, compounded over two years, is added to arrive at the hospital's Medicaid rate. The State Plan was approved by the Secretary, through his designee, the Regional Commissioner of the Social and Rehabilitation Service, on December 11, 1973.

The current rate set for the MGH at the time of the appeal was $265.95 per day for each Medicaid inpatient.

The reimbursement formulas for fiscal years ending September 30, 1974, 1975 and 1976, were the same in all respects pertinent to this case. They create a system of prospective rate making designed to reimburse each hospital on the basis of "reasonable costs" incurred in treating Medicaid inpatients and to encourage efficiency and economy.

It is appellant's position that the State formula does not provide that a hospital will be reimbursed its actual costs, which, it asserts, is required by Federal statute,[2] and that the Commission violated State laws[3] by setting rates for the appellant in specific amounts under a prospective rate system without affording it prior opportunity to be heard.

The Medicaid services rendered in medical facilities must be medically necessary and consistent with professionally recognized standards of care. 42 U.S.C. § 1320c-4(a)(1).

In order for the State to participate in Medicaid under the program authorized, Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., and 45 C.F.R. 250.30a, it must

[1] State regulations call for a reimbursement formula using as a rate base the actual historical cost of a hospital for a particular past year called a base year, being the twelve-month period two years prior to the rate year, which is the fiscal year covered by the regulation then in "operation."

[2] P.L. 92-603, Section 232, Volume 3, U.S. Code, Cong. & Adm. News, 92nd Congress, 2nd session (1972), p. 5087, 42 U.S.C. § 1396, et seq.

[3] Mass. G.L. c. 6A §§ 32, 36, and Mass. G.L. c. 30A, §§ 1, 2.

submit a plan to the Secretary of Health, Education and Welfare, detailing how it will fulfill the Federal conditions set forth in the Act and regulations thereunder. If the Secretary determines the conditions are met, he approves the plan, which he did in the case at bench. When implementing Section 232 of P.L. 92-603, the Secretary removed from 45 C.F.R. 250.30 the reference to the Secretary's approval being "on a demonstration or experimental basis."

When the Medicaid Act was enacted in 1965, the Secretary, and, in turn, the Courts, interpreted the Act to require the states to reimburse the hospital in the same manner as the allowable cost method was developed under the Medicare Act, to wit, the "costs actually incurred" by the hospital provider.

Section 1396a(a)(13)(D) of Title 42 U.S.C.,[4] as amended in 1972 by Sections 221 and 232 of Public Law 92-603, provides that state plans for reimbursement for Medicaid patients must provide for "reasonable costs" for such services, provided that such plans do not produce reimbursement in excess of that which would result in the application of Title XVIII (Medicare) standards and principles of cost reimbursement.

The implementing Federal regulation, 45 C.F.R. 250.30 (a), adopted in August, 1974, makes it clear that states, in their plans for reasonable costs, may adopt Title XVIII (Medicare) standards and principles, or alternative re-

[4] The Section provides, in relevant part: "(a) A State plan for medical assistance must— * * * (13) provide— (D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1320a-1 of this title, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1395x(v) of this title as the reasonable cost of such services for purposes of subchapter XVIII of this chapter."

imbursement plans that meet the criteria set out in the regulations which concern cost reporting. However, after December 31, 1973, payments to hospitals for Medicaid inpatient services shall be based on the lesser of the reasonable cost of services or the customary charges to the general public or, when applicable, in accordance with Title XVIII regulations. 45 C.F.R. 250.30(a)(2)(i)-(iii).

Appellants' principal objection to the State Plan is that it is based initially on the average cost per day of all inpatients in a given hospital rather than on the average daily cost of Medicaid inpatients per day, and that this method deprives appellant of its "reasonable costs" since it experienced substantially higher average daily costs for Medicaid inpatients than for non-Medicaid inpatients. It was agreed that there were other hospitals in the State whose costs for Medicaid inpatients averaged substantially less under the Plan than for non-Medicaid inpatients.

As observed by the district court, the legal issue is not whether the complex Plan is perfect, but whether under the Federal system of reimbursement, which has among its objectives the valid goal of providing incentives for efficiency and economy, the Plan can be said to provide for "payment of the reasonable cost of inpatient hospital services." The answer lies not in an assessment of policy, for that is the function of the state and Federal agencies, but in an analysis of the record presented to these agencies in light of the statutory and constitutional requirements. We conclude, as did the district court, that neither the language of the statute and regulations nor the evidence presented below supports appellant's contention in this case.

The hospital contends that Congress intended "reasonable costs" of inpatient hospital services under Medicaid to mean full payment of the actual cost thereof. If Congress had intended "reasonable costs" to be synonymous with "actual costs", however, there would have been no reason

for the amendments as promulgated by Public Law 92-603, 42 U.S.C. § 1396a(a)(13)(D), to provide for the "reasonable cost" program.

That the strict construction of the language is warranted can be readily concluded by reference to decisions interpreting the previous regulation. In *Catholic Medical Center of Brooklyn and Queens, Inc.* v. *Rockefeller,* 305 F. Supp. 1256 (E.D.N.Y. 1969) and *Connecticut State Department of Public Welfare* v. *Department of Health, Education and Welfare,* 448 F.2d 209 (2d Cir. 1971), the Federal courts involved turned aside the states' attempts to adopt a Medicaid reimbursement system different from Medicare. In reaching their decisions the courts there relied on the HEW's regulations requiring actual cost reimbursement and the arguments of HEW opposing the positions of the states. However, HEW has since changed its regulations to permit what was then prohibited. 45 C.F.R. 250.30(a) and (b). In the case at bench HEW is aligned with Massachusetts, having approved its plan. The Court in *Massachusetts General Hospital* v. *Sargent,* 397 F. Supp. 1056 (D. Mass. 1975), relied on the New York and Connecticut cases, supra, stating as to the effect of the regulations cited:

> "The Secretary's regulations have the force of federal law upon the States. *King* v. *Smith,* 392 U.S. 309, 317." *Id.* at 1061.

The Supreme Court, in *Mourning* v. *Family Publications Service, Inc.,* 411 U.S. 356, 371-73 (1973), comments, with respect to a regulation of the Federal Reserve Board, on the question of whether a measure chosen by an agency is reasonably related to its objectives, observing:

> "That some other remedial provision might be preferable is irrelevant. We have consistently held that where reasonable minds may differ as to which of several remedial measures should be chosen, courts should defer to the informed experience and judgment

of the agency to whom Congress delegated appropriate authority." *Id.* at 371-72.

Concerning the vesting of broad rule making power in an administrative agency, the Court states:

"In *American Trucking Assns.* v. *United States, supra,* we noted that it was not

> 'a reasonable canon of interpretation that the draftsmen of acts delegating agency powers, as a practical and realistic matter, can or do include specific consideration of every evil sought to be corrected . . . . [N]o great acquaintance with practical affairs is required to know that such prescience, either in fact or in the minds of Congress, does not exist. Its very absence, moreover, is precisely one of the reasons why regulatory agencies such as the Commission are created, for it is the fond hope of their authors that they bring to their work the expert's familiarity with industry conditions which members of the delegating legislatures cannot be expected to possess.' 344 U.S. 309-310 (citations omitted)."

411 U.S. 372-73.

The district court was well within bounds in determining that based on the evidence before HEW in 1973, the agency was not acting arbitrarily or capriciously when it approved as reasonable a reimbursement plan that treated the average cost of a Medicaid patient as if it were equal to the average cost of all patients. The evidence presented to the court established that HEW had carefully considered the question and concluded on substantial grounds that it lacked a sufficient basis for assuming the contrary. Nothing before the court indicated that adequate data to require a revision of the equation of the average Medicaid patient and the average patient was subsequently presented in an appropriate manner to the Rate Setting Commission.

Constitutional Claims

(a) . . *Due Process*

Appellant contends that the Commission deprived it of due process of law by setting the prospective rate in a specific amount without affording it a prior opportunity to be heard. While it appears that under Massachusetts law a public hearing may not be required before an individual rate is set, *see Beth Israel Hospital* v. *Rate Setting Commission,* Div. of Hearing Officers Appeal No. HD-74-26-H-302, ample opportunity exists under Massachusetts law to challenge both the propriety of the reimbursement formula and its application to appellant, satisfying the due process requirement. M.G.L. c. 6A, § 32 provides that the Massachusetts Rate Setting Commission "shall determine, after public hearing, at least as often as annually, the rates to be paid by each governmental unit to providers of health care service . . . ." Each rate set by the Commission is deemed a regulation and is reviewable under the procedures and standards of the Massachusetts Administrative Procedure Act, *id.*

A first appeal of an interim or final rate is to the Division of Hearings Officers, *see* M.G.L. c. 6A, § 36. Proceedings before that body are adjudicatory, *id.*, and are governed by the state Administrative Procedure Act. Each decision rendered must contain a determination of fact and law as well as a statement of reasons, M.G.L. c. 6A, § 36. Any party aggrieved by the decision of the Division of Hearings Officers has a right to petition for review by the Superior Court. *Id.* Procedures provided by M.G.L. c. 30A, § 14 govern. A hearing is conducted by the court sitting without a jury, M.G.L. c. 6A, § 14(6), which considers the record developed before the Commission, supplemented "upon such conditions as the court deems proper." M.G.L. c. 6A, § 14(7).

Although the Superior Court is to give due weight to the expertise of the agency and the discretion conferred upon it by the Legislature, it is authorized to affirm, remand, set aside, or modify the agency decision if it "determines that the substantial rights of any party may have been prejudiced . . . ." M.G.L. c. 6A, § 14(8). Among the conditions warranting court action are that the agency decision was "unsupported by substantial evidence . . .", § 14(8)(e), "Unwarranted by facts found by the court . . .", § 14(8)(f), or "Arbitrary or capricious, an abuse of discretion, or otherwise not in accordance with law.", § 14(8)(g). Review of the Superior Court decision is to the Appeals Court or the Supreme Judicial Court, which share concurrent jurisdiction. M.G.L. c. 30A, § 15.

A similar due process attack was waged against the review mechanisms provided by Massachusetts law in *Haverhill Manor, Inc.* v. *Commissioner of Public Welfare,* Mass. Adv. Sh. (1975) 1813. Plaintiff in that case, a nursing home, challenged the offset by the Commissioner of alleged overpayment from pre-1973 years against sums owing for 1973 on the ground that it had not been afforded a prior opportunity to be heard. The Supreme Judicial Court held that although the offset decision was not a regulation subject to hearing and appeal under M.G.L. c. 3A, §§ 3, 7, sufficient review was available by means of a declaratory judgment action to comport with due process. Such is the case here as well. Review is available before the Division of Hearings Officers, the Superior Court, and an appellate court.

(b) *Equal Protection.*

The equal protection test requires only, in establishing rates for different health care facilities, that the legislative classification have some "reasonable basis." It is not unconstitutional merely because the classification is not made with mathematical nicety or because in practice it results in some inequality. *Dandridge* v. *Williams,* 397 U.S. 471,

485 (1970). A legislative classification must be sustained if it is rationally related to a legitimate Government interest. *United States Dept. of Agriculture* v. *Moreno,* 413 U.S. 528, 533 (1973). The uniform treatment of urban teaching hospitals and rural hospitals is not a denial of equal protection as to appellant. Furthermore, the formula for determining prospective rates amply provides for the differences between an urban teaching hospital and a rural hospital.

(c) *Contract Impairment.*

Appellant asserts that its contract rights have been impaired by preventing reimbursement of reasonable cost for services rendered in violation of the United States Constitution, Article I, Section 10, Clause 1. This contention fails for lack of the establishment of any contract rights. The hospital's annual agreement with the State requires that it accept reimbursement rates which will be subsequently established by the Rate Setting Commission. M.G.L. c. 6A, § 35.

Appellant's argument throughout this proceeding has been that reimbursement in any amount less than its actual cost of treating Medicaid patients violates the statutory scheme. Case law and the legislative history of 42 U.S.C. § 1396a(a)(13)(D), refute that contention. The distinction between "actual" and "reasonable" costs was intentional on the part of the agency and reflects a policy judgment within its authority to make. There might be a case in which a hospital could demonstrate that the discrepancy between its actual costs and the level of reimbursement is so substantial that question of fact would arise to whether the effect of the regulation was to foreclose reasonable repayment and thus to be arbitrary and capricious. This was not such a case, however, for although plaintiff alleged some degree of undercompensation, as a matter of law it did not raise a sufficient question of unreasonableness to survive summary judgment.

We intend no comment on future litigation of this matter in federal court in which other evidence may show that the regulation causes a hospital to incur significant and unjustifiable losses, or that sufficient data has been developed to impeach any subsequent approval of the regulation as arbitrary and capricious. Nor should our decision prejudice other arguments addressed to other forums, such as the State Rate Setting Commission, in its yearly evaluation of the scheme, the state court, whose function it is to evaluate the state agency's compliance with state law, or HEW, in determining whether the assumptions underlying the Plan remain valid. Our conclusion here is that appellant has not carried its burden of proving that a genuine issue of material fact existed regarding the reasonableness of the regulation as it is applied to appellant.

The summary judgment of dismissal is *affirmed.*

Appendix C.

THE COMMONWEALTH OF MASSACHUSETTS
RATE SETTING COMMISSION
80 BOYLSTON STREET
BOSTON, MASSACHUSETTS 02116

REGULATION UNDER G.L. C. 7, SS. 30K-30P GOVERNING THE DETERMINATION OF RATES OF PAYMENT BY USE OF A PROSPECTIVE PER DIEM METHOD WITHOUT FINAL SETTLEMENT TO BE USED BY ALL GOVERNMENTAL UNITS FOR ALL INPATIENT AND WELL NEWBORN CARE PROVIDED PUBLICLY-AIDED PATIENTS AND BY USE OF A PERCENTAGE OF CHARGES METHOD WITHOUT FINAL SETTLEMENT TO BE USED BY ALL GOVERNMENTAL UNITS FOR ALL OUTPATIENT CARE PROVIDED PUBLICLY-AIDED PATIENTS ON AND AFTER APRIL 1, 1974 BY HOSPITALS, SANATORIA AND INFIRMARIES; AND FOR ALL CARE AND SERVICES RENDERED TO PUBLICLY-AIDED PATIENTS IN LEVEL 1, 2, AND 3 HEALTH CARE FACILITIES OPERATING UNDER A HOSPITAL LICENSE

Regulation Number 74-1.

1. *Short Title*

This regulation shall be known and may be cited as the Commission's "Hospital Prospective Rate Setting Regulation."

2. *Scope and Purpose*

Rates of payment for all inpatient, outpatient, and well newborn hospital care and services rendered to publicly-aided patients on and after April 1, 1974, shall be determined under the provisions of G.L. c.7, ss. 30K-30P and in accordance with this regulation.

The intention of this regulation is to establish a prospective rate determination method to be applicable to providers of inpatient, outpatient and well newborn hospital care and services. In the Commission's view such a method will produce fair and reasonable rates of payment that will promote increasing efficiencies in the operations of providers covered hereunder. Such efficiencies will contribute to the provision of quality health care at reasonable cost. As a result the Commission expects this method of rate determination to provide payors on behalf of publiciy-aided patients with assurance that they will receive maximum health benefits from their expenditures.

The provisions of this regulation shall, where indicated, apply to provider long-term care facilities.

The provisions of this regulation are to be read and applied consistently with the requirements of the Economic Stabilization Program. The intent and application of this regulation and rates hereunder is to determine rates as requried by G.L. c.7, ss.30K-30P, which, however, are consistent with federal law under the Economic Stabilization Program. No rate is effective under this regulation insofar as it contravenes the express mandate or intent of the applicable federal standards under the Economic Stabilization Program.

3. *Definitions*

The following terms, as used in this regulation, shall have the following meanings:

"*Base year,*" the second year preceding the rate year.

"*Commission,*" the Rate Setting Commission appointed under G.L. c.7, s.30L.

"*Department,*" the Massachusetts Department of Public Health established under G.L. c.17, s.1.

"*Economic Stabilization Program,*" The Federal economic regulatory program established under the Economic Stabilization Act of 1970 and amendments thereto, and any Executive Orders, rulings and policy determinations thereunder.

"*Intermediate Year,*" the fiscal year of a provider preceding the rate year.

"*Provider long-term care facilities,*" health care facilities offering levels 1, 2, and 3 care, or any combination of these levels of care as a unit of a provider, in a building physically attached to the plant facility of a provider, or in an independent free-standing facility operating under a license issued to a provider by the Department; for purposes of this definition, levels 1, 2, and 3 care shall be defined in "Rules and Regulations for the Licensing of Long-Term Care Facilities," adopted by the Department on January 12, 1971, and as they may from time to time be amended.

"*Provider of Inpatient, Outpatient or Well Newborn Health Care and Services* or "provider," a hospital, as defined in G.L. c.111, s.52, owned or operated by the Commonwealth or any agency thereof, licensed by the Department of Mental Health under G.L. c.19, s.2, or by the Department of Public Health under G.L. c.111, s.51, or certified by the Department for participation in the program established under Title XIX of the federal Social Security Act, which hospital provides health care and services for inpatients, outpatients or the well newborn on an inpatient basis.

"*Publicly-Aided Patient,*" which is synonymous with "public assistance patient," a person for whose inpatient, outpatient and newborn hospital care and services the Commonwealth or an agency thereof is in whole or in part liable under a statutory program of public assistance.

"*Rate Year,*" the first fiscal year of a provider beginning on or after October 1, 1973, for the portion of which beginning

on April 1, 1974 a final rate of payment is to be established under this regulation.

4. *Final Rate of Payment for Inpatient Service*

4.1 Subject to sections 6.5, 9, 12, and except for rates determined under section 8, a final all-inclusive per diem rate of payment for inpatient services provided to publicly-aided patients by a provider during the rate year shall be determined as follows:

(a) The provider's total reimbursable inpatient operating cost for the base year, determined in accordance with sections 4.2 and 13, is to be adjusted forward over a two-year period by use of an inflation factor of 7.5% per annum, to produce the provider's reimbursable rate year inpatient operating cost.*

(b) To the provider's reimbursable rate year inpatient operating cost is added its reimbursable inpatient non-operating cost, determined in accordance with section 5.

(c) The sum of (a) and (b) above is then divided by allowable inpatient days determined in accordance with section 6.

4.2 The final all-inclusive per diem rate of payment for well newborn inpatient services provided to publicly-aided patients by a provider during the rate year shall be equal to one-third of the rate established under section 4.1.

4.3 A provider's total reimbursable inpatient operating cost shall be derived from the provider's HCF-400 or HCF-100 cost report filed with the Commission for the provider's base year. The Commission in determining a final rate of payment for a

* The inflation factor of 7.5% per annum is intended to apply for the rate year governed by this regulation only. In the event the system established under this regulation is to be extended beyond said rate year, the Commission shall review the applicable inflation factor from year to year thereafter to determine the appropriate factor to be used.

provider under this section, may use cost information contained in said report prior to Commission audit.

5. *Reimbursable Non-Operating Cost*

5.1 In order to establish the amount of a provider's reimbursable non-operating cost, for purposes of sections 4.1 and 4.2 the following calculations are made:

(a) Total base year reimbursable non-operating cost in the following categories is established (categories appear in HCF-400, Schedule V-B):

(1) Provision for depreciation — buildings
(2) Provision for depreciation — fixed equipment
(3) Provision for depreciation — Major moveable equipment
(4) Interest Expense
(5) Rental of Hospital Lands and Buildings
(6) Real Estate and other Property Taxes
(7) Legal Fees and Expenses

(b) Total base year hospital cost is established, being the sum of inpatient operating costs, ambulatory service costs, and non-patient expenses of the provider in the base year.

(c) Total base year reimbursable non-operating cost is divided by total base year hospital cost to produce a loading factor.

(d) Reimbursable inpatient non-operating cost is determined by multiplying the provider's reimbursable inpatient operating cost for the base year, determined under section 4.1 prior to application of the inflation factor, by the loading factor established under section 5.1 (c).

6. *Allowable Inpatient Days*

6.1 To establish a provider's allowable inpatient days for purposes of the calculation under section 4.1 (c), the provider's total inpatient days in the base year are divided into maternity

inpatient days, non-maternity inpatient days, and adjusted newborn days. Maternity inpatient and non-maternity inpatient days are adjusted, as may be required, under sections 6.3, 6.4 respectively, and under section 6.5; adjusted newborn inpatient days are determined in accordance with section 6.6. The totals of each, after any such adjustments, are combined to produce the number of allowable inpatient days for purposes of section 4.1 (c)

6.2 Available bed days, as used in sections 6.3, 6.4 and 6.5, shall mean the total number of bed days of a provider available for maternity and non-maternity purposes and as reported by the provider for the base year.

6.3 To establish the maternity component of allowable inpatient days, the provider's actual maternity inpatient days in the base year, or 60% of the provider's available maternity bed days in the base year, as defined in section 6.2, is used, whichever is greater.

6.4 To establish the non-maternity component of allowable inpatient days, the provider's actual non-maternity inpatient days in the base year, or 75% of available non-maternity bed days, as defined in section 6.2, is used, whichever is greater. For providers classified as teaching facilities according to Appendix A, attached to this regulation and incorporated herein by reference, 80% shall be substituted for 75% for purposes of this subsection.

6.5 The Commission recognizes that efficient administration of a provider may sometimes require that maternity beds be used for strictly gynecological rather than maternity and related services, and further recognizes that in the base year cost report the provider may have reported the use of such beds under actual non-maternity inpatient days while the beds may figure in the reported available maternity bed days. In some instances such a situation may result in a penalty for such provider by operation of the adjustment required under section 6.3. If such a penalty has occurred in establishing a final rate of payment for a provider under section 4, the provider may submit to the Commission information on the number of reported actual non-maternity inpatient days that represent provision of strictly gynecological services to patients occupying maternity beds. Upon petition of such a provider, the Commission shall recalculate the provider's final rate of payment by adding that number of patient days to the provider's actual maternity inpatient days and subtracting that number from the provider's actual non-maternity inpatient days. If such recalculation produces a final rate of payment higher than that initially established for such provider, the Commission shall establish said higher rate as the provider's final rate of payment. A change in a provider's rate of payment under this section shall be in addition to any right of said provider to seek an adjustment in rate under the provisions of section 9.

6.6 To establish adjusted newborn inpatient days, well newborn patient days, as reported by the provider for the base year, are multiplied by one-third.

6.7 Because of the particular geographic location on Nantucket Cottage Hospital and Martha's Vineyard Hospital, only the actual maternity inpatient days for those providers in the base year shall be used for purposes of section

7. *Final Rate of Payment for Outpatient Services*

7.1 Subject to sections 9, 12.1, and 12.2, a final rate of payment for outpatient services provided to publicly-aided patients by a provider during the rate year shall be determined by computing the ratio of the provider's total reimbursable outpatient operating and non-operating cost for the base year, determined in accordance with sections 7.2 and 13, to the provider's total allowable charges for outpatient services during the base year. Said ratio, expressed as a percentage, shall be

applied to the provider's billed charges during the rate year for outpatient services rendered to publicly-aided patients. Said ratio, expressed as a percentage, shall in no event exceed 100%.

7.2. A provider's total reimbursable outpatient operating and non-operating cost shall be derived from the provider's HCF-400 or RSC-100 cost report filed with the Commission for the provider's base year. The Commission, in determining a final rate of payment for a provider under this section, may use cost information contained in said report prior to Commission audit.

7.3 Each provider shall file with the Commission within thirty days of the commencement of its rate year a full and complete list of all outpatient charges in effect for such providers as of the beginning of the rate year. The percentage developed as the final rate of payment under this section shall be applied to the provider's outpatient charges in effect as of the beginning of the rate year as filed with the Commission to the extent such charges are allowable. If such charges have not been filed with the Commission, the percentage shall be applied to the most current prior allowable outpatient charge on file with the Commission.

7.4 Any charge in a provider's outpatient charges to the general public applicable to publicly-aided patients from the schedule of outpatient charges on file with the Commission and in effect as of the beginning of the provider's rate year shall not be effective for purposes of establishing a final rate of payment under this section and for receiving payment for such services unless such changes in charges have been approved by the Commission. All proposed changes in such outpatient charges shall be filed with the Commission for approval at least sixty (60) days prior to their becoming effective for the purpose of establishing a final rate of payment and receiving payment under this section. Such notification shall contain the following:

(a) A justification of the reasonableness of the proposed charge in relation to the provider's ratio of total reimbursable outpatient operating and non-operating cost to the provider's total allowable outpatient charges, to adequately reimburse the provider for outpatient services on a reasonable cost basis;

(b) A description of the provider's historical outpatient cost-charge relationship; and

(c) A certification identical to that required under section 14.3.

Approval of any changes in such charges shall be deemed to have been granted in the absence of notification to the contrary by the Commission within sixty (60) days after such filing, except that this presumption shall not apply insofar as it contravenes the provisions of the Economic Stabilization Program.

8. *Rate of Payment: Level 1, 2, and 3 Health Care Facilities*

8.1 Interim and final rates of payment for services rendered to pubicly-aided patients in provider long-term care facilities shall be determined in accordance with the Commission's regulation governing rates of payment to long-term care facilities (Regulation 73-12 and successor regulations).

9. *Adjustments*

9.1 Except as required by sections 6.5, 12.1, 12.2, or 16 no final rate of payment established under sections 4 and 7, and no interim rate established under section 8, shall be adjusted during the rate year unless such adjustment is governed by the provisions of this section.

9.2 A provider may apply to the Commission for an adjustment to a final rate of payment, or an interim rate of payment in the case of provider long-term care facilities, during the rate year for any of the reasons specified in section 9.3. Any such

application shall contain information sufficient and in such detail as to permit the Commission to translate the expeditures relating to the incident giving rise to the application and any related project proposed by the applicant, where applicable, into reimbursable operating and non-operating costs for the rate year. In all cases applicants under section 9.3 shall have the burden of assuring the adequacy of information provided to the Commission to justify an adjustment. Any rate adjustment resulting from such application shall be effective as of a date specified by the Commission, which date shall, in the Commission's opinion, be most suited to reflect appropriate reimbursement for any additional financial commitments incurred by the applicant as a result of the incident giving rise to the application and any related project proposed by the applicant, where applicable. Any adjustment made under this subsection shall be valid only with respect to the incident as specified and described in an application.

9.3 A provider may seek an adjustment in a rate of payment under section 9.2 if any of the following incidents occurred during the intermediate year or except for incidents described in section 9.3 (b), occur during the rate year:

(a) The provider has incurred or expects to incur a substantial capital expenditure, or has made or expects to make a substantial change in services, subject to a determination of need by the Department under G.L. c.111, sections 25B to 25G, inclusive. Such application shall be made after the Department has determined that need exists for the project proposed by the applicant, and after either the time for taking an appeal with respect to such determination to the Health Facilities Appeals Board, established under G.L. c.6, s.166, has expired or all administrative and judicial reviews of such determination have been concluded; provided, however, that any such application may be made prior to such determination with the approval of the Commissioner of Public Health; and

provided, further, that upon request of the Commissioner of Public Health, the Commission may determine the appropriate amount of any such adjustment before a determination of need is made by the Department with respect to the expenditure or change proposed by the applicant.

(b) The provider has undertaken during the intermediate year a substantial program change not requiring a determination of need from the Department. Every application under this subsection shall contain, in addition to information required under section 9.2, a statement of the justification for the program change and a description of any review of the program change that may have been undertaken by the Department or by a comprehensive health planning agency. Where any such application indicates that the incident which is the subject of the application will produce only a relatively insubstantial change in the rate of the applicant provider, the Commission may, in its discretion, choose not to review such application on its merits. In reviewing applications under this subsection, the Commission may request, or may require that the applicant request, a review of the application by the Department or by a comprehensive health planning agency.

(c) The provider has incurred or expects to incur costs necessary to satisfy requirements of the Department or another governmental unit relative to the safety of patients, the quality of service provided by such provider, or the fiscal operations of such provider. Any such application shall be accompanied by written certification or a copy of an official notice from the Department or other governmental unit detailing the additional requirements imposed on the provider and specifying the statutory or regulatory authority under which such requirements are imposed.

(d) There has been an arm's length transfer of ownership of the provider for good and valuable consideration, provided that any adjustment resulting from such an incident shall be

limited to reflecting only increases in non-operating costs resulting directly from such transfer.

(e) The provider has been granted an exception under the Economic Stabilization Program permitting an increase in costs in excess of that ordinarily allowed under such Program, as a result of action by the appropriate agency empowered to grant such exceptions. Any such application shall be accompanied by a copy of the formal notification of an exception being granted by said appropriate agency.

9.4 The Commission may, on its own motion, order a reduction in the rate of a provider where it finds that such provider has reduced its cost merely by transferring a part of its cost, as reported in the base year, to other persons who provide health care and services, as, for example, where a provider reduces its salaries paid to physicians by requiring that physicians who previously performed certain services for the provider in return for such salary bill patients directly for the provision of such services. A provider shall report any such transfer to the Commission within seven (7) days of its completion. Failure to comply with this requirement shall subject the provider to the penalties imposed by G.L. c.7, s. 30N.

9.5 The Commission may, on its own motion, require an adjustment in the rate of a provider established under section 4 where such rate had been established on the basis of unaudited base year cost information and subsequent audit reveals substantial error in the costs as reported by the provider.

10. *New Providers*

10.1 A provider which anticipates commencement of services for the first time after the effective date of this regulation shall have a final rate of payment for inpatient, outpatient and well newborn services established pursuant to this section. If such provider maintains a provider long-term care facility the

rates for such facility shall be determined in accordance with the Commission's regulation governing rates of payment to long-term care facilities.

10.2 Any such provider of inpatient, outpatient and well newborn services shall apply to the Commission for a final rate of payment before commencement of such services. Such an application shall contain sufficient information to permit a projection of the provider's operating and non-operating costs and utilization rates during the first twelve months of its operation. All or any portion of an application submitted to the Department for a determination of need under G.L. c.111, section 51 may be submitted as an application under this section, provided the information contained therein is sufficient to satisfy the requirement of the preceding sentence. Upon receipt of such application the Commission shall establish a final rate of payment for such provider based on its evaluation of the information contained in such application.

11. *Rate for Providers with Inadequate Cost Information*

11.1 Where there is adequate cost information available to allow determination of rates of payment under sections 4, 7, and 8 for a provider, other than a provider subject to section 10, and until such time as there is sufficient cost information available to allow determination of rates of payment for such provider under said sections, the Commission shall establish rates for such provider based on

(a) Current rates then in effect for comparable providers;

(b) Allowable actual expenditures and utilization experience of the provider to the extent such information is available;

(c) Satisfactory cost and utilization projections provided to the Commission.

12. *Limitation on Rates*

12.1 No rate established under sections 7, 8, and no outpatient rate established under section 10 for a provider shall exceed the rate payable to such provider by a third party payor, nor shall any rate established under sections 4, 7, 8 or 10 exceed the charges of such provider to members of the general public for services that are also provided for publicly-aided patients. Inasmuch as the final rate of payment for the rate year may be established hereunder in advance of revisions in the provider's rate structure which are to be effective during the rate year, upon any such revision becoming effective, the Commission shall, if necessary, recompute the final rate of payment for such provider to assure that the aggregate amount of payments by governmental units for services rendered to publicly-aided patients for the rate year do not exceed the provider's charges for such services.

12.2 (a) The Commission recognized that, because of the difficulty of comparing an all-inclusive rate with charges for a variety of services, there may be some impediments to implementing the requirements of section 12.1 that inpatient rates established hereunder shall not exceed providers' charges to the general public. The Commission finds, however, that the rate established for a provider for inpatient services rendered to industrial accident patients under the Workmen's Compensation Act provides a basis for implementing said provision of section 12.1, inasmuch as the methodology for establishing said industrial accident rate requires conversion of a provider's charge to a per diem rate. For valid comparison, however, the most current available charges should be used in calculating said industrial accident rate, whether the industrial accident rate officially established by the Commission under M.G.L. c.7, s.30L, reflects said charges or not. Consequently, the rate established under section 4 and any inpatient

rate established under section 10 for a provider shall not exceed the rate that would have been established for payment to said provider for services rendered to industrial accident patients if the most current available routine and ancillary charges of the provider were used by the Commission in establishing said rate for the provider (hereinafter, "imputed industrial accident rate"). If during the rate year a provider to whom the rate limitation established under this subsection is applied validly increases its charges, said provider's imputed industrial accident rate shall be recalculated using said new charges, and if the rate so calculated exceeds the rate limitation previously established hereunder, said higher rate shall constitute the rate limitation for purposes of this subsection, effective as of the date said charge increase becomes effective. Under no condition shall use of an imputed industrial accident rate produce a rate for the provider higher than that produced under section 4 of section 10, as the case may be.

12.3 Application of the reimbursement principles contained in this regulation shall not produce reimbursement in excess of that which would result from application of the principles of provider reimbursement established under Title XVIII of the Social Security Act.

13. *Allowable Costs*

13.1 Allowable costs to be included in the calculation of a final rate or payment for a provider under sections 4 and 7 are those costs of the provider that are reasonable and related to patient care. Allowable costs that are to be included in the calculation of rates of payment for provider long-term care facilities shall be determined by the provisions of the Commission's regulation governing rates of payment to long-term care facilities and shall not be determined by the provisions of this section. Except as otherwise provided in this regulation, al-

lowable cost for inpatient, outpatient and well newborn care shall be determined in accordance with the principles of reimbursement developed for determining payments under Title XVIII of the federal Social Security Act. In determining the reasonableness of any cost to be included in calculating a provider's final rate of payment, the Commission shall apply the "prudent buyer" concept, which assumes that any premium paid by a provider above the going price for a supply or service and any amount paid by a provider for a service or supply in excess of the market price for the service or supply is to be excluded from allowable costs.

13.2 Depreciation shall be included as an allowable cost provided that it is based on historical cost and is computed on the straight-line method. The estimated useful life of a depreciable asset shall be determined in accordance with either Bulletin F of the Internal Revenue Service or Section 1 of the Handbook on Accounting, Statistics and Business Office Procedures for Hospitals (Publication M10-50) of the American Hospital Association (copyright 1950). The basis for depreciation of an asset donated to the provider shall be the basis of the asset in the donor's hands.

13.3 In the case of proprietary providers, allowable cost shall include allowance for a reasonable return on equity capital invested and used in the provision of patient care. The amount allowable on an annual basis shall be determined by applying to the provider's equity capital in the base year the percentage return recognized as an allowable cost for purposes of determining payments under Title XVIII of the federal Social Security Act during the provider's base year. The amount of equity capital to be used for computing the allowable return shall be the average of the provider's equity capital at the beginning of the base year and the provider's equity capital at the end of the base year.

13.4 Allowable costs shall not include any provision for bad debts, charity, and courtesy allowances; provided, however, that allowable costs shall include an appropriate recognition of those bad debts of a provider arising solely from failure of a publicly-aided patient to provide for payment of any copayment or coninsurance feature for which he is liable, once eligibility for public assistance has been established, pursuant to a cost-sharing plan established under state law or required under Title XIX of the federal Social Security Act, but only if the provider has made bona fide effort to collect same, and has been unable to do so, pursuant to a written plan for collection of bad debt on file with the Commission.

13.5 Consistent with the principles of reimbursement developed for determining payments under Title XVIII of the federal Social Security Act, allowable costs shall include, but not be limited to:

(a) Necessary and proper interest on both current and capital indebtedness;

(b) An appropriate part of the net cost of approved educational activities;

(c) The value of services performed by non-paid workers who work more than twenty hours per week in full-time positions of kinds that are normally occupied by paid personnel of providers not operated by or related to religious orders, provided that such amounts are identifiable in the provider's records as a legal obligation that the non-paid workers are members of organizations under arrangements with the provider for which such services are rendered without direct remuneration to the non-paid workers by either organization; and

(d) A reasonable allowance of compensation for services of owners, provided such services are actually performed in a necessary function.

13.6 Allowable cost shall not include payments under consulting contracts, payments to professional organizations, trade associations and the like, or payments to area-wide comprehensive health planning agencies formed under section 3 (b) of the federal Public Health Service Act, unless the reporting requirements contained in sections 3 and 7 of the Commission's Regulation Number 71-33 are followed with respect to such costs. Said regulation is attached hereto and the sections thereof relevant to this subsection and to section 13.7 are incorporated herein by reference.

13.7 (a) Salaries, fees, commissions or other types of remuneration paid to any employee of a provider, including but not limited to licensed physicians for service rendered to such provider and its patients shall not be allowable costs where payment for the same service is reimbursed under any fee schedule by a third party payor or is paid directly by the patient. In order to recognize as an allowable cost of a provider any salary, fee, commission or other type of remuneration paid to any employee of the provider who also bills on a fee for service basis, such provider must comply with the reporting requirements set forth in section 2 of the Commission's Regulation Number 71-33.

(b) Cost incurred by a provider in leasing equipment of facilities shall be an allowable cost only to the extent that such cost does not exceed the allowable cost which would have been recognized if the provider had purchased the equipment or facilities and does not exceed rental charges of comparable equipment or facilities in the area. Costs incurred in leasing equipment or facilities, the terms of which lease provide for the ownership of the equipment or the facilities by the provider at the end of the term of the lease for no further payment or for a nominal payment, shall be deemed to be an actual purchase, and costs associated with such lease shall not be allowed; however, if such equipment or facility is recorded in

the provider's plant ledger, depreciation on such equipment or facility will be allowed in accordance with section 13.2 above.

(c) Allowable cost under this regulation shall not reflect the nursing service differential provided for under Title XVIII of the federal Social Security Act.

14. *Reporting Requirements*

14.1 All providers subject to this regulation shall file with the Commission a complete and acceptable "Hospital Statement for Reimbursement" HCF-400 and HCF-400A Reports or RSC-100 Report, or such other report as the Commission may require on an annual or quarterly basis. Providers which maintain provider long-term care facilities shall file with the Commission on an annual basis the Commission's RSC-1 Report for long-term care facilities, or such other report as the Commission may require on an annual or quarterly basis, and shall make available all records and books relating to said facility, including such data, statistics, records and books relating to a Realty, Holding or Service Company, the provider, or any legal entity in which there is a common ownership between the facility and said Realty, Holding or Service Company or the provider. Annual reports shall be filed by the end of the third calendar month following the close of the provider's fiscal year, and quarterly reports, if required, shall be filed within forty-five days of the close of the provider's fiscal quarter. The Executive Secretary to the Commission may grant an extension of the time for filing any such report after written request from the provider setting forth the reasons for such request, if the Executive Secretary finds that good cause exists for such extension. The Executive Secretary shall report on the granting of any such extension to the Commission. Reporting forms the filing of which shall be initially required by the Commission (HCF-400, HCF-400A, RSC-100,

RSC-1) are attached hereto and incorporated herein by reference, including instructions contained therein.

14.2 Any financial report required to be filed with the Commission under this section shall be completed in accordance with generally accepted accounting principles and in accordance with Commission regulations, including this regulation and the Commission's Regulation Number 71-33. Such reports shall be certified by the chief executive officer or financial officer of the provider.

14.3 For all periods covered by Executive Order 11615 and 11627, and until these Orders are rescinded, all financial reports submitted to the Commission under this section must include the following certification:

> "I hereby certify that the amounts claimed herein do not exceed the maximum levels established in accordance with Executive Order 11615, August 15, 1971, as modified by Executive Order 11627, October 15, 1971, and are in compliance with the provisions of Title VI of the Code of Federal Regulations entitled Economic Stabilization."

14.4 In addition to charge information required to be filed under section 7.3, each provider shall file with the Commission within thirty days of the commencement of the rate year a full and complete list of all routine and special inpatient and well newborn charges in effect for such provider as of the beginning of the rate year. Each provider shall report to the Commission any change in any such charge during the rate year within fifteen days of the effective date of such change.

14.5 All providers subject to this regulation shall file such additional information as the Commission may from time to time reasonably require.

15. *Exclusions*

15.1 Final rates of payment established under this regulation shall not apply to payment for the following services or supplies:

(a) whole blood;

(b) services of optometrists, dentists, or chiropodists, or other practitioners who bill the patient directly for such services;

(c) special duty nursing services;

(d) artificial appliances;

(e) eyeglasses;

(f) radio and television

(g) materials taken home to be used by the patient after discharge from the provider; and

(h) services reimbursed from other sources or under a separate fee.

16. *Appeals*

16.1 Any provider aggrieved by a rate of payment established pursuant to this regulation including an adjustment to a rate of payment under sections 6.5 and 9, or aggrieved by the failure of the Commission to adjust a rate pursuant to an application filed under section 9, may file an appeal with the Commission within thirty (30) days of the filing of any such rate or rate adjustment with the Secretary of State, or within thirty (30) days of the date the provider receives notices that the Commission will not adjust a rate following the filing of an application under section 9. Any such appeal must actually be received in the office of the Executive Secretary within such thirty (30) day period.

16.2 Appeals hereunder shall be governed by the provisions of G.L. c.7, s. 30O and by the Commission's "Rules of Practice and Procedure." No provision of said section or of said

Rules shall, however, be construed as abrogating the principles of reimbursement established under this regulation.

16.3 Appeals shall be in writing and shall contain the following information:

(a) The name and address of the provider appellant;

(b) The rate or rate adjustment appealed from or the request for rate adjustment on which the Commission refused to take action;

(c) A clear and concise statement of the facts upon which the appeal is based;

(d) A clear and concise statement of the relief, including the rate sought;

(e) Except in the case of institutions owned and operated by the Commonwealth or any agency or political sub-division thereof, a certification by the official who initiates the appeal that the governing body of the institution vote expressly and specifically to authorize the action; and

(f) For all periods covered by Executive Orders 11615 and 11627, and until these orders are rescinded, the following certification:

> "I hereby certify that the amounts claimed herein do not exceed the maximum levels established in accordance with Executive Order 11615, August 15, 1971, as modified by Executive Order 11627, October 15, 1971, and in compliance with the provisions of Title VI of the Code of Federal Regulations entitled "Economic Stabilization."

16.4 Any appeal that fails to conform to the requirements of section 16.3 shall be denied without hearing by the Commission.

16.5 On appeal, the validity of any rate established for a provider shall be judged solely on the basis of its conformity

with the principles governing determination of rates of payment as set forth in this regulation.

16.6 Where a provider files a timely appeal, the staff of the Commission may file specifications of other issues on which it wishes to present evidence relative to determination of the rate appealed from.

Appendix D.

COMMONWEALTH OF MASSACHUSETTS
RATE SETTING COMMISSION
80 BOYLSTON STREET
BOSTON, MASSACHUSETTS 02116

REGULATION UNDER G.L. c.6A, ss. 31-36 GOVERNING THE DETERMINATION OF RATES OF PAYMENT BY USE OF A PROSPECTIVE PER DIEM METHOD WITHOUT FINAL SETTLEMENT TO BE USED BY ALL GOVERNMENTAL UNITS FOR ALL INPATIENT AND WELL NEWBORN CARE PROVIDED PUBLICLY-AIDED PATIENTS AND BY USE OF A PERCENTAGE OF CHARGES METHOD WITHOUT FINAL SETTLEMENT TO BE USED BY ALL GOVERNMENTAL UNITS FOR ALL OUTPATIENT CARE PROVIDED PUBLICLY-AIDED PATIENTS ON AND AFTER OCTOBER 1, 1974 BY HOSPITALS, SANATORIA AND INFIRMARIES; AND FOR ALL CARE AND SERVICES RENDERED TO PUBLICLY-AIDED PATIENTS IN LEVEL 1, 2, AND 3, HEALTH CARE FACILITIES OPERATING UNDER A HOSPITAL LICENSE.

Regulation Number 74-26.

1. *Short Title*

This regulation shall be known and may be cited as the Commission's "Hospital Prospective Rate Setting Regulation."

2. *Scope and Purpose*

Rates of payment for all inpatient, outpatient, and well newborn hospital care and services rendered to publicly-aided patients on and after October 1, 1974, shall be determined under the provisions of G.L. c. 6A, ss. 31-36 and in accordance with this regulation.

The intention of this regulation is to establish a prospective rate determination method to be applicable to providers of inpatient, outpatient and well newborn hospital care and services. In the Commission's view such a method will produce fair, reasonable and adequate rates of payment that will promote increasing efficiencies in the operations of providers covered hereunder. Such efficiencies will contribute to the provision of quality health care at reasonable cost. As a result the Commission expects this method of rate determination to provide payors on behalf of publicly-aided patients with assurance that they will receive maximum health benefits from their expenditures.

The provisions of this regulation shall, where indicated, apply to provider long-term care facilities.

3. *Definitions*

The following terms, as used in this regulation, shall have the following meanings:

"*Base year,*" the second year preceding the rate year.

"*Commission,*" the Rate Setting Commission appointed under G.L. c.6A, s.32.

"*Department,*" the Massachusetts Department of Public Health established under G.L. c.17, s.1.

"*Governmental Unit,*" The Commonwealth, any department, agency, board or Commission of the Commonwealth, and any political subdivision of the Commonwealth; and shall include, for purposes of Section 9.3(c) only, in addition to the foregoing, an instrumentality of the federal government of the United States.

"*Intermediate Year,*" the fiscal year of a provider preceding the rate year.

"*Provider long-term care facilities,*" health care facilities offering levels 1, 2, and 3 care, or any combination of these

levels of care as a unit of a provider, in a building physically attached to the plant facility of a provider, or in an independent free-standing facility operating under a license issued to a provider by the Department; for purposes of this definition, levels 1, 2, and 3 care shall be defined in "Rules and Regulations for the Licensing of Long-Term Care Facilities," adopted by the Department on January 12, 1971, and as they may from time to time be amended.

"*Provider of Inpatient, Outpatient or Well Newborn Health Care and Services,*" or "provider," a hospital, as defined in G.L. c.111, s.52, owned or operated by the Commonwealth or any agency thereof, licensed by the Department of Mental Health under G.L. c.19, s.2, or by the Department of Public Health under G.L. c.111, s.51, or certified by the Department for participation in the program established under Title XIX of the federal Social Security Act, which hospital provides health care and services for inpatients, outpatients or the well newborn on an inpatient basis.

"*Publicly-Aided Patient,*" which is synonymous with "public assistance patient," a person for whose inpatient, outpatient and newborn hospital care and services a governmental unit is in whole or in part liable under a statutory program of public assistance.

"*Rate Year,*" the first fiscal year of a provider beginning on or after October 1, 1974.

4. *Final Rate of Payment for Inpatient Services*

4.1 Subject to sections 6.5, 9, 12, and except for rates determined under section 8, a final all-inclusive per diem rate of payment for inpatient services provided to publicly-aided patients by a provider during the rate year shall be determined as follows:

(a) The provider's total reimbursable inpatient operating cost for the base year, determined in accordance with sections 4.2 and 13, is to be adjusted forward over a two-year period by use of an inflation factor as described in section 4.4, to produce the provider's reimbursable rate year inpatient operating cost.*

(b) To the provider's reimbursable rate year inpatient operating cost is added its reimbursable inpatient non-operating cost, determined in accordance with section 5.

(c) The sum of (a) and (b) above is then divided by allowable inpatient days determined in accordance with section 6.

4.2 The final all-inclusive per diem rate of payment for well newborn inpatient services provided to publicly-aided patients by a provider during the rate year shall be equal to one-third of the rate established under section 4.1.

4.3 A provider's total reimbursable inpatient operating cost shall be derived from the provider's HCF-400 or RSC-100 cost report filed with the Commission for the provider's base year. Where field audited information is not available at the time of the development of a rate for a provider under this section, the Commission shall use cost information contained in said report prior to Commission audit, but shall in any event make known adjustments to such report in developing such rate. A "known adjustment" shall consist of a mathematical error, an historically recurring adjustment to a provider's cost report and items clearly not reimbursable under this regulation.

4.4 The inflation factor referred to in section 4.1(a) shall be developed as follows:

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* The inflation factor developed under section 4.4 is intended to apply for the rate year governed by this regulation only. In the event the system established under this regulation is to be extended beyond said rate year, the Commission shall review the applicable inflation factor from year to year thereafter to determine the appropriate factor to be used.

(a) An initial inflation rate of 10% per annum shall be used in developing rates under section 4.

(b) Before the end of the rate year, the Commission shall determine indicators to be applied to components of provider base year costs to measure the change in such costs by reference to changes in related cost categories experienced in the economy generally since the base year. If the application of such indicators produces inflation factors substantially at variance from the initial inflation factor used under section 4.4(a), an appropriate adjustment shall be made to reflect the difference between the rate as calculated using said initial inflation factor and the rate that would have been calculated had the initial inflation factor been equal to the inflation factor produced under this subsection.

5. *Reimbursable Non-Operating Cost*

5.1 In order to establish the amount of a provider's reimbursable non-operating cost, for purposes of sections 4.1 and 4.2 the following calculations are made:

(a) Total base year reimbursable non-operating cost in the following categories is established (categories appear in HCF-400, Schedule V-B):

(1) Provision for depreciation — buildings

(2) Provision for depreciation — fixed equipment

(3) Provision for depreciation — Major moveable equipment

(4) Interest Expense

(5) Rental of Hospital Lands and Buildings

(6) Real Estate and other Property Taxes

(7) Legal Fees and Expenses

(b) Total base year hospital cost is established, being the sum of inpatient operating costs, ambulatory service costs, and non-patient expenses of the provider in the base year.

(c) Total base year reimbursable non-operating cost is divided by total base year hospital cost to produce a loading factor.

(d) Reimbursable inpatient non-operating cost is determined by multiplying the provider's reimbursable inpatient operating cost for the base year, determined under section 4.1 prior to application of the inflation factor, by the loading factor established under section 5.1 (c).

6. *Allowable Inpatient Days*

6.1 To establish a provider's allowable inpatient days for purposes of the calculation under section 4.1 (c), the provider's total inpatient days in the base year are divided into maternity inpatient days, non-maternity inpatient days, and adjusted newborn days. Maternity inpatient and non-maternity inpatient days are adjusted, as may be required, under sections 6.3, 6.4 respectively, and under section 6.5; adjusted newborn inpatient days are determined in accordance with section 6.6. The totals of each, after any such adjustments, are combined to produce the number of allowable inpatient days for purposes of section 4.1 (c)

6.2 Available bed days, as used in sections 6.3, 6.4 and 6.5, shall mean the total number of bed days of a provider available for maternity and non-maternity purposes in the base year.

6.3 To establish the maternity component of allowable inpatient days, the provider's actual maternity inpatient days in the base year, or 60% of the provider's available maternity bed days in the base year, as defined in section 6.2, is used, whichever is greater.

6.4 To establish the non-maternity component of allowable inpatient days, the provider's actual non-maternity inpatient days in the base year, or 75% of available non-maternity bed days, as defined in section 6.2, is used, whichever is greater.

For providers classified as teaching facilities according to Appendix A, attached to this regulation and incorporated herein by reference, 80% shall be substituted for 75% for purposes of this subsection.

6.5 The Commission recognizes that efficient administration of a provider may sometimes require that maternity beds be used for strictly gynecological rather than maternity and related services, and further recognizes that in the base year cost report the provider may have reported the use of such beds under actual non-maternity inpatient days while the beds may figure in the reported available maternity bed days. In some instances such a situation may result in a penalty for such provider by operation of the adjustment required under section 6.3. If such a penalty has occurred in establishing a final rate of payment for a provider under section 4, the provider may submit to the Commission information on the number of reported actual non-maternity inpatient days that represent provision of strictly gynecological services to patients occupying maternity beds. Upon petition of such a provider, the Commission shall recalculate the provider's final rate of payment by adding that number of patient days to the provider's actual maternity inpatient days and subtracting that number from the provider's actual non-maternity inpatient days. If such recalculation produces a final rate of payment higher than that initially established for such provider, the Commission shall establish said higher rate as the provider's final rate of payment. A change in a provider's rate of payment under this section shall be in addition to any right of said provider to seek an adjustment in rate under the provisions of section 4.

6.6 To establish adjusted newborn inpatient days, well newborn patient days, as reported by the provider for the base year, are multiplied by one-third.

6.7 Because of the particular geographic location of Nantucket Cottage Hospital and Martha's Vineyard Hospital, only

the actual maternity inpatient days for those providers in the base year shall be used for purposes of sections 6.3.

7. *Final Rate of Payment for Outpatient Services*

7.1 Subject to sections 9, 12.1, and 12.2, a final rate of payment for outpatient services provided to publicly-aided patients by a provider during the rate year shall be determined by computing the ratio of the provider's total reimbursable outpatient operating cost for the base year, determined in accordance with sections 7.2 and 13, to the provider's total allowable charges for outpatient services during the base year. Said ratio, expressed as a percentage, shall be applied to the provider's billed charges during the rate year for outpatient services rendered to publicly-aided patients. Said ratio, expressed as a percentage, shall in no event exceed 100%.

7.2. A provider's total reimbursable outpatient operating and non-operating cost shall be derived from the provider's HCF-400 or RSC-100 cost report filed with the Commission for the provider's base year. Where field audited information is not available at the time of the development of a rate for a provider under this section, the Commission shall use cost information contained in said report prior to Commission audit, but shall in any event make known adjustments to such report in developing such rate. A "known adjustment" shall consist of a mathematical error, an historically recurring adjustment to a provider's cost report and items clearly not reimbursable under this regulation.

7.3 Each provider shall file with the Commission within thirty days of the commencement of its rate year a full and complete list of all outpatient charges in effect for such provider as of the beginning of the rate year. The percentage developed as the final rate of payment under this section shall be applied to the provider's outpatient charges in effect as of

the beginning of the rate year as filed with the Commission to the extent such charges are allowable. If such charges have not been filed with the Commission, the percentage shall be applied to the most current prior allowable outpatient charge on file with the Commission.

7.4 Any change in a provider's outpatient charges to the general public applicable to publicly-aided patients from the schedule of outpatient charges on file with the Commission and in effect as of the beginning of the provider's rate year shall not be effective for purposes of establishing a final rate of payment under this section and for receiving payment for such services unless such changes in charges have been approved by the Commission. All proposed changes in such outpatient charges shall be filed with the Commission for approval at least sixty (60) days prior to their becoming effective for the purpose of establishing a final rate of payment and receiving payment under this section. Such notification shall contain the following:

(a) A justification of the reasonableness of the proposed charge in relation to the provider's ratio of total reimbursable outpatient operating and non-operating cost to the provider's total allowable outpatient charges, to adequately reimburse the provider for outpatient services on a reasonable cost basis; and

(b) A description of the provider's historical outpatient cost-charge relationship.

Approval of any changes in such charges shall be deemed to have been granted in the absence of notification to the contrary by the Commission within sixty (60) days after such filing.

8. *Rate of Payment: Level 1, 2, and 3 Health Care Facilities*

8.1 Interim and final rates of payment for services rendered to publicly-aided patients in provider long-term care facilities

shall be determined in accordance with the Commission's regulation governing rates of payment to long-term care facilities (Regulation 74-11 and successor regulations).

9. *Adjustments*

9.1 Except as required by sections 6.5, 12.1, 12.2, or 16, no final rate of payment established under sections 4 and 7, and no interim rate established under section 8, shall be adjusted during the rate year unless such adjustment is governed by the provisions of this section.

9.2 A provider may apply to the Commission for an adjustment to a final rate of payment, or an interim rate of payment in the case of provider long-term care facilities, during the rate year for any of the reasons specified in section 9.3. Any such application shall contain information sufficient and in such detail as to permit the Commission to translate the expeditures relating to the incident giving rise to the application and any related project proposed by the applicant, where applicable, into reimbursable operating and non-operating costs for the rate year. In all cases applicants under section 9.3 shall have the burden of assuring the adequacy of information provided to the Commission to justify an adjustment. Any rate adjustment resulting from such application shall be effective as of a date specified by the Commission, which date shall, in the Commission's opinion, be most suited to reflect appropriate reimbursement for any additional financial commitments incurred by the applicant as a result of the incident giving rise to the application and any related project proposed by the applicant, where applicable. Any adjustment made under this subsection shall be valid only with respect to the incident as specified and described in an application.

9.3 A provider may seek an adjustment in a rate of payment under section 9.2 if any of the following incidents occurred

during the intermediate year or except for incidents described in section 9.3 (b), occur during the rate year:

(a) The provider has incurred or expects to incur a substantial capital expenditure, or has made or expects to make a substantial change in services, subject to a determination of need by the Department under G.L. c.111, sections 25B to 25G, inclusive. Such application shall be made after the Department has determined that need exists for the project proposed by the applicant, and after either the time for taking an appeal with respect to such determination to the Health Facilities Appeals Board, established under G.L. c.6, s.166, has expired or all administrative and judicial reviews of such determination have been concluded; provided, however, that any such application may be made prior to such determination with the approval of the Commissioner of Public Health; and provided, further, that upon request of the Commissioner of Public Health, the Commission may determine the appropriate amount of any such adjustment before a determination of need is made by the Department with respect to the expenditure or change proposed by the applicant.

(b) The provider has undertaken during the intermediate year a substantial program change not requiring a determination of need from the Department. Every application under this subsection shall contain, in addition to information required under section 9.2, a statement of the justification for the program change and a description of any review of the program change that may have been undertaken by the Department or by a comprehensive health planning agency. Where any such application indicates that the incident which is the subject of the application will produce only a relatively insubstantial change in the rate of the applicant provider, the Commission may, in its discretion, choose not to review such application on its merits. In reviewing applications under this subsection, the Commission may request, or may require that

the applicant request, a review of the application by the Department or by a comprehensive health planning agency.

(c) The provider has incurred or expects to incure costs necessary to satisfy requirements of the Department or another governmental unit relative to the safety of patients, the quality of service provided by such provider, or the fiscal operations of such provider. Any such application shall be accompanied by written certification or a copy of an official notice from the Department or other governmental unit detailing the additional requirements imposed on the provider and specifying the statutory or regulatory authority under which such requirements are imposed.

(d) There has been an arm's length transfer of ownership of the provider for good and valuable consideration, provided that any adjustment resulting from such an incident shall be limited to reflecting only increases in non-operating costs resulting directly from such transfer.

(e) The provider has experienced unusual, or unforeseen increases in reasonable operating costs not compensated for by the initial inflation factor established in section 4.4(a) which are of such a degree as to gravely threaten the financial stability of the provider.

9.4 The Commission may, on its own motion, order a reduction in the rate of a provider where it finds that such provider has reduced its cost merely by transferring a part of its cost, as reported in the base year, to other persons who provide health care and services, as, for example, where a provider reduces its salaries paid to physicians by requiring that physicians who previously performed certain services for the provider in return for such salary bill patients directly for the provision of such services. A provider shall report any such transfer to the Commission within seven (7) days of its completion. Failure to comply with this requirement shall subject the provider to the penalties imposed by G.L. c.6A, s.35.

9.5 The Commission may, on its own motions, require an adjustment in the rate of a provider established under section 4 where such rate had been established on the basis of unaudited base year cost information and subsequent audit reveals substantial error in the costs as reported by the provider.

10. *New Providers*

10.1 A provider which anticipates commencement of services for the first time after the effective date of this regulation shall have a final rate of payment for inpatient, outpatient and well newborn services established pursuant to this section. If such provider maintains a provider long-term care facility the rates for such facility shall be determined in accordance with the Commission's regulation governing rates of payment to long-term care facilities.

10.2 Any such provider of inpatient, outpatient and well newborn services shall apply to the Commission for a final rate of payment before commencement of such services. Such an application shall contain sufficient information to permit a projection of the provider's operating and non-operating costs and utilization rates during the first twelve months of its operation. All or any portion of an application submitted to the Department for a determination of need under G.L. c.111, section 51 may be submitted as an application under this section, provided the information contained therein is sufficient to satisfy the requirement of the preceding sentence. Upon receipt of such application the Commission shall establish a final rate of payment for such provider based on its evaluation of the information contained in such application.

11. *Rate for Providers with Inadequate Cost Information*

11.1 Where there is inadequate cost information available to allow determination of rates of payment under sections 4, 7,

and 8 for a provider, other than a provider subject to section 10, and until such time as there is sufficient cost information available to allow determination of rates of payment for such provider under said sections, the Commission shall establish rates for such provider based on

(a) Current rates then in effect for comparable providers;

(b) Allowable actual expenditures and utilization experience of the provider to the extent such information is available;

(c) Satisfactory cost and utilization projections provided to the Commission.

12. *Limitation on Rates*

12.1 No rate established under sections 7, 8, and no outpatient rate established under section 10 for a provider shall exceed the rate payable to such provider by a third party payor, nor shall any rate established under sections 4, 7, 8 or 10 exceed the charges of such provider to members of the general public, for services that are also provided for publicly-aided patients. Inasmuch as the final rate of payment for the rate year may be established hereunder in advance of revisions in the provider's rate structure which are to be effective during the rate year, upon any such revision becoming effective, the Commission shall, if necessary, recompute the final rate of payment for such provider to assure that the aggregate amount of payments by governmental units for services rendered to publicly-aided patients for the rate year do not exceed the provider's charges for such services.

12.2 The Commission recognized that, because of the difficulty of comparing an all-inclusive rate with charges for a variety of services, there may be some impediments to implementing the requirements of section 12.1 that inpatient rates established hereunder shall not exceed providers' charges to the general public. The Commission finds, however, that

the rate established for a provider for inpatient services rendered to industrial accident patients under the Workmen's Compensation Act provides a basis for implementing said provision of section 12.1, inasmuch as the methodology for establishing said industrial accident rate requires conversion of a provider's charge to a per diem rate. For valid comparison, however, the most current available charges should be used in calculating said industrial accident rate, whether the industrial accident rate officially established by the Commission under G.L. c.6A, s.32, reflects said charges or not. Consequently, the rate established under section 4 and any inpatient rate established under section 10 for a provider shall not exceed the rate that would have been established for payment to said provider for services rendered to industrial accident patients if the most current available routine and ancillary charges of the provider were used by the Commission in establishing said rate for the provider (hereinafter, "imputed industrial accident rate"). If during the rate year a provider to whom the rate limitation established under this subsection is applied validly increases its charges, said provider's imputed industrial accident rate shall be recalculated using said new charges, and if the rate so calculated exceeds the rate limitation previously established hereunder, said higher rate shall constitute the rate limitation for purposes of this subsection, effective as of the date said charge increase becomes effective. Under no condition shall use of an imputed industrial accident rate produce a rate for the provider higher than that produced under section 4 or section 10, as the case may be.

12.3 Application of the reimbursement principles contained in this regulation shall not produce reimbursement in excess of that which would result from application of the principles of provider reimbursement established under Title XVIII of the Social Security Act.

13. *Allowable Costs*

13.1 Allowable costs to be included in the calculation of a final rate or payment for a provider under sections 4 and 7 are those costs of the provider that are reasonable and related to patient care. Allowable costs that are to be included in the calculation of rates of payment for provider long-term care facilities shall be determined by the provisions of the Commission's regulation governing rates of payment to long-term care facilities and shall not be determined by the provisions of this section. Except as otherwise provided in this regulation, allowable cost for inpatient, outpatient and well newborn care shall be determined in accordance with the principles of reimbursement developed for determining payments under Title XVIII of the federal Social Security Act. In determining the reasonableness of any cost to be included in calculating a provider's final rate of payment, the Commission shall apply the "prudent buyer" concept, which assumes that any premium paid by a provider above the going price for a supply or service and any amount paid by a provider for a service or supply in excess of the market price for the service or supply is to be excluded from allowable costs.

13.2 Depreciation shall be included as an allowable cost provided that it is based on historical cost and is computed on the straight-line method. The estimated useful life of a depreciable asset shall be determined in accordance with either Bulletin F of the Internal Revenue Service or Section 1 of the Handbook on Accounting, Statistics and Business Office Procedures for Hospitals (Publication M10-50) of the American Hospital Association (copyright 1950). The basis for depreciation of an asset donated to the provider shall be the basis of the asset in the donor's hands.

13.3 In the case of proprietary providers, allowable cost shall include allowance for a reasonable return on equity capi-

tal invested and used in the provision of patient care. The amount allowable on an annual basis shall be determined by applying to the provider's equity capital in the base year the percentage return recognized as an allowable cost for purposes of determining payments under Title XVIII of the federal Social Security Act during the provider's base year. The amount of equity capital to be used for computing the allowable return shall be the average of the provider's equity capital at the beginning of the base year and the provider's equity capital at the end of the base year.

13.4 Allowable costs shall not include any provision for bad debts, charity, and courtesy allowances; provided, however, that allowable costs shall include an appropriate recognition of those bad debts of a provider arising solely from failure of a publicly-aided patient to provide for payment of any copayment or coninsurance feature for which he is liable, once eligibility for public assistance has been established, pursuant to a cost-sharing plan established under state law or required under Title XIX of the federal Social Security Act, but only if the provider has made bona fide effort to collect same, and has been unable to do so, pursuant to a written plan for collection of bad debt on file with the Commission.

13.5 Consistent with the principles of reimbursement developed for determining payments under Title XVIII of the federal Social Security Act, allowable costs shall include, but not be limited to:

(a) Necessary and proper interest on both current and capital indebtedness;

(b) An appropriate part of the net cost of approved educational activities;

(c) The value of services performed by non-paid workers who work more than twenty hours per week in full-time positions of kinds that are normally occupied by paid personnel of providers not operated by or related to religious orders, pro-

vided that such amounts are identifiable in the provider's records as a legal obligation that the non-paid workers are members of organizations under arrangements with the provider for which such services are rendered without direct remuneration to the non-paid workers by either organization; and

(d) A reasonable allowance of compensation for services of owners, provided such services are actually performed in a necessary function.

13.6 Allowable cost shall not include payments under consulting contracts, payments to professional organizations, trade associations and the like, or payments to area-wide comprehensive health planning agencies formed under section 314(b) of the federal Public Health Service Act, unless the reporting requirements contained in sections 3 and 7 of the Commission's Regulation Number 71-33 are followed with respect to such costs. Said regulation is attached hereto and the sections thereof relevant to this subsection and to section 13.7 are incorporated herein by reference.

13.7 (a) Salaries, fees, commissions or other types of remuneration paid to any employee of a provider, including but not limited to licensed physicians, for service rendered to such provider and its patients shall not be allowable costs where payment for the same service is reimbursed under any fee schedule by a third party payor or is paid directly by the patient. In order to recognize as an allowable cost of a provider any salary, fee, commission or other type of remuneration paid to any employee of the provider who also bills on a fee for service basis, such provider must comply with the reporting requirements set forth in section 2 of the Commission's Regulation Number 71-33.

(b) Cost incurred by a provider in leasing equipment of facilities shall be an allowable cost only the extent that such cost does not exceed the allowable cost which would have been rec-

ognized if the provider had purchased the equipment or facilities and does not exceed rental charges of comparable equipment or facilities in the area. Costs incurred in leasing equipment or facilities, the terms of which lease provide for the ownership of the equipment or the facilities by the provider at the end of the term of the lease for no further payment or for a nominal payment, shall be deemed to be an actual purchase, and costs associated with such lease shall not be allowed; however, if such equipment or facility is recorded in the provider's plant ledger, depreciation on such equipment or facility will be allowed in accordance with section 13.2 above.

(c) Allowable cost under this regulation shall not reflect the nursing service differential provided for under Title XVIII of the federal Social Security Act.

14. *Reporting Requirements*

14.1 All providers subject to this regulation shall file with the Commission a complete and acceptable "Hospital Statement for Reimbursement" HCF-400 and HCF-400A Reports or RSC-100 Report, or such other report as the Commission may require on an annual or quarterly basis. Providers which maintain provider long-term care facilities shall file with the Commission on an annual basis the Commission's RSC-1 Report for long-term care facilities, or such other report as the Commission may require on an annual or quarterly basis, and shall make available all records and books relating to said facility, including such data, statistics, records and books relating to a Realty, Holding or Service Company, the provider, or any legal entity in which there is a common ownership between the facility and said Realty, Holding or Service Company or the provider. Annual reports shall be filed by the end of the third calendar month following the close of the provider's fiscal year, and quarterly reports, if required, shall be filed within forty-five days of the close of the provider's

fiscal quarter. The Executive Secretary to the Commission may grant an extension of the time for filing any such report after written request from the provider setting forth the reasons for such request, if the Executive Secretary finds that good cause exists for such extension. The Executive Secretary shall report on the granting of any such extension to the Commission. Reporting forms the filing of which shall be initially required by the Commission (HCF-400, HCF-400A, RSC-100, RSC-1) are attached hereto and incorporated herein by reference, including instructions contained therein.

14.2 Any financial report required to be filed with the Commission under this section shall be completed in accordance with generally accepted accounting principles and in accordance with Commission regulations, including this regulation and the Commission's Regulation Number 71-33. Such reports shall be certified by the chief executive officer or financial officer of the provider.

14.3 For all reporting periods covered in whole or in part by Executive Order 11615 and 11627, issued under the Economic Stabilization Act of 1970, all financial reports submitted to the Commission under this section must include the following certification:

> "I hereby certify that the amounts claimed herein do not exceed the maximum levels established in accordance with Executive Order 11615, August 15, 1971, as modified by Executive Order 11627, October 15, 1971, and are in compliance with the provisions of Title VI of the Code of Federal Regulations entitled Economic Stabilization."

14.4 In addition to charge information required to be filed under section 7.3, each provider shall file with the Commission within thirty days of the commencement of the rate year a

full and complete list of all routine and special inpatient and well newborn charges in effect for such provider as of the beginning of the rate year. Each provider shall report to the Commission any change in any such charge during the rate year within fifteen days of the effective date of such change.

14.5 All providers subject to this regulation shall file such additional information as the Commission may from time to time reasonably require.

15. *Exclusions*

15.1 Final rates of payment established under this regulation shall not apply to payment for the following services or supplies:

(a) whole blood;

(b) Services of optometrists, dentists, or chiropodists, or other practitioners who bill the patient directly for such services;

(c) special duty nursing services;

(d) artificial appliances;

(e) eyeglasses;

(f) radio and television

(g) materials taken home to be used by the patient after discharge from the provider; and

(h) services reimbursed from other sources or under a separate fee.

16. *Appeals*

16.1 Any provider aggrieved by a rate of payment established pursuant to this regulation including an adjustment to a rate of payment under sections 6.5 and 9, or aggrieved by the failure of the Commission to adjust a rate pursuant to an application filed under section 9, may file an appeal with the Commission within thirty (30) days of the filing of any such

rate or rate adjustment with the Secretary of State, or within thirty (30) days of the date the provider receives notices that the Commission will not adjust a rate following the filing of an application under section 9.

16.2 Appeals hereunder shall be governed by the provisions of G.L. c.6A, s.36 and by such rules as may be established by said Division of Hearings Officers. No provision of said section or of said Rules shall, however, be construed as abrogating the principles of reimbursement established under this regulation.

17. *Informational Bulletin*

The Commission may, from time to time, issue informational bulletins interpreting or expanding upon provisions of this regualtion. Such builetins shall be deemed to be incorporated as part of this regulation, shall be distributed to providers, rates for which are determined under this regulation, and shall be accessible to the public at the Commission's offices during Commission business hours.

Appendix E.

TITLE 14 — RATE SETTING COMMISSION

CHAPTER I — BUREAU OF HOSPITALS AND CLINICS

Part 3 — Prospective Inpatient, Outpatient, and Well Newborn Rate Determination

Subpart A — General Provisions

Sec.

3.01 Scope, Purpose, and Effective Date
3.02 Disclaimer and Authorization of Services
3.03 Care Included under this Part
3.04 Authority

s 3.01 *Scope, Purpose, and Effective Date*

This part governs prospective rates of payment for inpatient, outpatient, and well newborn hospital care and services provided to publicly aided individuals during the rate year from October 1, 1975 through September 30, 1976. This part shall be effective from the date of its publication by the Secretary of the Commonwealth.

s 3.02 *Disclaimer and Authorization of Services*

This part is not an authorization for or approval of the substantive program of hospital care and services included within this part. Governmental units which purchase hospital care and services under this part are responsible for definition, authorization, and approval of health care and services provided to publicly aided individuals.

s 3.03 *Care Included under this Part*

Rates of payment under this part shall include payment for all inpatient, outpatient, and well newborn hospital care and services which are provided by a hospital to publicly aided individuals, subject to an agreement for hospital care and services between the hospitals and governmental unit.

s 3.04 *Authority*

This part is adopted pursuant to G.L.c.6A, §§ 31-36. This citation of authority conforms to 1 CHSR 26.45.

s 3.13 *Publicly Aided Individual*

A person who receives hospital care and services for which a governmental unit is in whole or part liable under a statutory program of public assistance.

s 3.14 *Teaching Hospital*

A hospital which maintains accredited teaching programs as listed in the *Directory of Approved Internships and Residencies of the American Medical Association.*

Subpart C — Rate Determination Definitions

Sec.

3.16 Meaning of Terms
3.17 Reasonable Cost
3.18 HCF 400
3.19 RSC 401
3.20 Base Year
3.21 Intermediate Year
3.22 Rate Year
3.23 Equity Factor
3.24 Inflation Factor

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3.27 Base Year Non Operating Cost
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3.30 Base Year Ambulatory Service Cost
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3.35 Adjusted Newborn Inpatient Days
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3.37 Adjusted Non Maternity Inpatient Days
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3.39 Rate Year Inpatient Non Operating Cost
3.40 Rate Year Inpatient Operating Cost
3.41 Outpatient Cost to Charge Ratio
3.42 Total Base Year Outpatient Charges
3.43
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3.45

s 3.16 *Meaning of Terms*

As used in this part, unless the context requires otherwise, terms shall have the meanings described in this subpart.

s 3.17 *Reasonable Cost*

A cost incurred by a hospital in providing hospital care and services, provided that such cost is necessary, comparable to the cost of providing similar care and services and consistent with the prudent buyer concept.

s 3.18 *HCF 400*

The hospital statement for reimbursement which is filed with the Commission for the base year or intermediate year and which is completed in accord with the requirements of this part.

s 3.19 *RSC 401*

The hospital statement for reimbursement which is filed with the Commission for the 1975 fiscal year and which is completed in accord with the requirements of this part.

s 3.20 *Base Year*

The hospital fiscal year ending September 30, 1974. In the case of municipal hospitals, the base year shall be the fiscal year ending June 30, 1974.

s 3.21 *Intermediate Year*

The hospital fiscal year ending September 30, 1975. In the case of municipal hospitals, the intermediate year shall be the fiscal year ending June 30, 1975.

s 3.22 *Rate Year*

The period from October 1, 1975 through September 30, 1976.

s 3.23 *Equity Factor*

10.86% of equity capital invested and used in the provision of hospital care and services by a proprietary hospital during the base year

s 3.24 *Inflation Factor*

A rate of 9% per year which represents the reasonable change in inpatient operating costs for inflation from the intermediate year through the rate year.

s 3.25 *Known Adjustment*

An adjustment pursuant to subpart E which is made to an unaudited HCF 400, which involves correction of a mathematical error, reallocation of an historically recurring cost to the appropriate cost category, or rejection of a cost which is not reimbursed under this part.

s 3.26 *Loading Factor*

The quotient of base year non operating cost as adjusted pursuant to subpart E divided by total base year hospital cost.

s 3.27 *Base Year Non Operating Cost*

The non operating cost reported by a hospital for the base year, set forth in Schedule V B of HCF 400.

s 3.28 *Total Base Year Hospital Cost*

The sum of base year inpatient operating cost, base year ambulatory service cost, and base year non patient expense, all as adjusted pursuant to subpart E.

s 3.29 *Base Year Inpatient Operating Cost*

The inpatient operating cost reported by a hospital for the base year, set forth in Schedule VI of HCF 400.

s 3.30 *Base Year Ambulatory Service Cost*

The ambulatory service cost reported by a hospital for the base year, set forth in Schedule VI of HCF 400.

s 3.31 *Base Year Non Patient Expense*

The non patient expense reported by a hospital for the base year, set forth in Schedule VI of HCF 400.

s 3.32 *Allowed Inpatient Days*

The sum of adjusted maternity inpatient days, adjusted newborn inpatient days, and adjusted non maternity inpatient days.

s 3.33 *Maternity Inpatient Days*

Actual maternity inpatient days for the base year. In the case of a hospital which uses maternity beds for gynecology patients, maternity inpatient days shall be the sum of actual maternity inpatient days for the base year plus actual gynecology inpatient days generated from use of maternity beds for the base year.

s 3.34 *Adjusted Maternity Inpatient Days*

The higher of maternity inpatient days in the base year or 60% of the total number of maternity available bed days in the base year. In the case of Nantucket Cottage Hospital and Martha's Vineyard Hospital, adjusted maternity inpatient days shall be actual maternity inpatient days.

s 3.35 *Adjusted Newborn Inpatient Days*

One third of the actual well newborn inpatient days for the base year.

s 3.36 *Non Maternity Inpatient Days*

Actual inpatient days for the base year for all inpatients other than maternity and well newborn inpatients.

s 3.37 *Adjusted Non Maternity Inpatient Days*

The higher of non maternity inpatient days or 75% of the total number of non maternity available bed days in the base year or 80% of the total number of non maternity available bed days in the base year in the case of those teaching hospitals listed in section 3.14.

s 3.38 *Available Bed Days*

The product of the number of beds licensed by the Department of Public Health during the base year and the number of calendar days in the base year.

s 3.39 *Rate Year Inpatient Non Operating Cost*

The product of base year inpatient operating cost as adjusted pursuant to subpart E multiplied by the loading factor.

s 3.40 *Rate Year Inpatient Operating Cost*

The base year inpatient operating cost as adjusted pursuant to subpart E and as projected through the rate year by the inflation factor.

s 3.41 *Outpatient Cost to Charge Ratio*

The ratio, expressed as a percentage:

$$\frac{\text{(base year ambulatory service cost as adjusted pursuant to subpart E x loading factor)}}{\text{total base year outpatient charges as adjusted pursuant to subpart E and as allowed pursuant to subpart H}}$$

s 3.42 *Total Base Year Outpatient Charges*

Gross ambulatory service charges for the base year as reported on Schedule II of HCF 400.

Subpart D — Filing and Reporting Requirements

Sec.

3.46 Required Reports and Records
3.47 Filing Dates

3.48 Penalty for Late or Inadequate Filing
3.49
3.50

s 3.36 *Required Reports and Records*

(a) Each hospital shall file the HCF 400 and appropriate schedules. These reports are to be completed in accord with the instructions set forth therein; in accord with generally accepted accounting principles; and pursuant to requirements of RSC Reg. 71-33, administrative information bulletins of RSC Reg. 74-26, and this part.

(b) Each hospital shall file the RSC 401 and RSC 411A and appropriate schedules. These reports are to be completed in accord with the instructions set forth therein and pursuant to requirements of this part to insure uniform and comparable reporting. Copies of these reports, schedules, and instructions are incorporated herein and are annexed hereto.

(c) Each new hospital shall file a proposed hospital budget and projected volume and revenue data for the rate year in such form and content as the Commission may require.

(d) Each hospital shall file a copy of its three year capital expenditure budget which is required under 42 U.S.C. §§ 1395 *et seq.*, the medicare act.

(e) Each hospital shall file a complete schedule of all outpatient charges and shall amend that schedule as outpatient charges are changed during the rate year.

(f) Each hospital shall comply with the filing and reporting requirements of RSC Reg. 71-33, §§ 2, 3, 7 in regard to fees, salaries, commissions, or any other remuneration paid for services for which payment is made in whole or in part by third party payers or self insured persons; consultant contracts; and payments to professional organizations, trade associations, and the like. The physician service form, PS-1, must be filed for each physician who is a member of the medical staff.

(g) Each hospital shall notify the Commission in writing of any transfer of costs as set forth in section 3.77.

(h) Each hospital shall file its credit and collection plan and free service plan with the Commission.

(i) Each hospital shall file such additional information as the Commission may from time to time require.

(j) Each hospital shall make available all books and records relating to its operation and its program of hospital care and services.

(k) All reports, schedules, budgets, information, books, and records which are filed with or made available to the Commission shall be certified as true, correct, and accurate by the chief executive officer or financial officer of the hospital.

(l) A hospital which fails or refuses to file or make available required reports, schedules, budgets, information, books, and records shall forego determination and further certification of rates for its hospital care and services.

s 3.47 *Filing Dates*

(a) The RSC 401 for the fiscal year ending September 30, 1975 or the fiscal year ending June 30, 1975 in the cae of municipal hospitals and the three year capital expenditure budget shall be filed within 90 days from October 1.

(b) The RSC 401 for the fiscal year ending September 30, 1976 or the fiscal year ending June 30, 1976 in the case of municipal hospitals and the three year capital expenditure budget shall be filed within 90 days from the close of the fiscal year.

(c) RSC 401A shall be filed within 45 days from the close of the quarter for each quarter of the rate year or each quarter after June 30, 1975 in the case of municipal hospitals.

(d) The credit and collection plan and free service plan shall be filed with and at the same time that RSC 401 is filed.

Amendments to these plans shall be filed not later than 60 days prior to the proposed effective date.

(e) Each new hospital shall file a proposed hospital budget and projected volume and revenue data for the rate year not later than 60 days prior to beginning patient care.

(f) Each hospital shall file a complete schedule of all current outpatient charges on the first day of the rate year. Amendments to this schedule shall be filed 60 days prior to the effective date of proposed change to the schedule of all outpatient charges.

(g) Each hospital shall file the information and reports required by RSC Reg. 71-33, §§ 2, 3, 7 within 90 days from the close of the fiscal year. Amendments to these reports and information shall be filed within 45 days from the date of changed circumstances.

(h) Each hospital shall file a report of any transfer of cost as set forth in section 3.77 within 7 days of that transfer.

(i) All other information shall be filed within 30 days from the date of request unless a different time limit is set forth in the request.

(j) The chairman of the Commission may, for cause, extend the filing date for submission of reports, schedules, budgets, information, books, and records.

s 3.48 *Penalty for Late or Inadequate Filing*

Where there has been a late or inadequate filing of required reports, schedules, budgets, information, books, and records, the Commission may determine an effective date for the rates determined under this part which reflects the time lost by late or inadequate filing.

Subpart E — Rate Determination, General Provisions

Sec.

3.51 Reimbursement as Full Payment
3.52 Inpatient, Well Newborn Rate Limitation
3.53 Outpatient Rate Limitation
3.54 Adjustments to Hospital Costs Reports
3.55 Allowable Cost
3.56 Excluded Cost
3.57
3.58
3.59
3.60

s 3.51 *Reimbursement as Full Payment*

Reimbursement or payment for care and services purchased from hospitals which provide hospital care and services shall be determined in accord with the provisions of this part, and each hospital which provides care and services shall, as a condition to receipt of such reimbursement or payment, accept reimbursement at rates established by this Commission, subject to appellate rights set forth in G.L. c. 6A, § 36, as full payment and discharge of all obligations of publicly aided individuals for the care and services purchased under this part. There shall be no duplication or supplementation of payment.

s 3.52 *Inpatient, Well Newborn Rate Limitation*

(a) Inpatient and well newborn rates determined under this part for a hospital will not exceed that reimbursement or payment which would result from application of the Principles of Reimbursement for Provider Costs established under 42 U.S.C. §§ 1395, *et seq.*, the medicare act.

(b) Inpatient rates determined under this part for a hospital will not exceed its charges to the general public for the same care and services. For purposes of this section, a hospital's charges to the general public for inpatient care and services shall be imputed in accordance with the formula:

$$\left(\begin{array}{l}\text{average semi private room and board charge intended to be effective on October 1, 1975 and as approved pursuant to Chapter 424 of the Acts of 1975 and 14 CHSR 4}\end{array} + \begin{array}{l}\text{total gross special service charges for adults and children for the base year}\end{array}\right) \times \text{inflation factor}$$

$$+$$

$$\frac{\text{total gross special service charges for well newborn for the base year}}{\text{maternity and non maternity days for the base year + one third of the well newborn days for the base year}}$$

(c) Well newborn rates determined under this part for a hospital will not exceed its charges to the general public for the same care and services. For purposes of this section, a hospital's charges to the general public for well newborn care

and services shall be one third of the imputed charge set forth in subsection (b).

s 3.53 *Outpatient Rate Limitation*

(a) Outpatient rates determined under this part shall not exceed that reimbursement or payment which would result from application of the Principles of Reimbursement for Provider Costs established under 42 U.S.C. §§ 1395 *et seq.*, the medicare act.

(b) Outpatient rates determined under this part will not exceed the rates payable to a hospital by any third party payor.

(c) Outpatient rates determined under this part will not exceed charges to the general public as approved pursuant to Chapter 424 of the Acts of 1975.

s 3.54 *Adjustments to Hospital Cost Reports*

Rates determined under this part shall be calculated from audited and adjusted HCF 400 statements when possible. Audited HCF 400 statements will be adjusted to reflect allowable cost and to reject excluded costs. Unaudited HCF 400 statements from which rates are calculated under this part will be adjusted through the use of known adjustments to reflect allowable cost and to reject excluded costs.

s 3.55 *Allowable Cost*

(a) Pursuant to the requirements and rate determination formulas of this part, hospitals will be reimbursed for allowable costs. These costs must be reasonable costs and must be directly related to hospital care and services.

(b) Except as otherwise required in this part and the instructions to HCF 400, allowable costs for inpatient, outpatient, and well newborn hospital care and services shall be determined in accord with the Principles of Reimbursement for Provider Costs under 42 U.S.C. §§ 1395 *et seq.* as set forth in 20 CFR 405, *et seq.* and the *Provider Reimbursement Manual.*

(c) Depreciation shall be an allowable cost provided that it is based on historical cost and is calculated by the straight line method. The useful life of an asset shall be determined in accordance with section 1 of the *Handbook on Accounting, Statistics, and Business Office Procedures for Hospitals* (Publication M10-50, American Hospital Association, 1950).

(d) Costs for leased facilities and fixed equipment shall be an allowable cost to the extent that such costs do not exceed the allowable cost which would have been recognized if the hospital had purchased the equipment or facilities and to the extent that such costs do not exceed rental charges of comparable equipment or facilities.

(e) Costs for equipment and facilities leased under contractual provisions which provide a purchase option at the end of the lease term without more than nominal payment will not be allowed. Depreciation will be allowed pursuant to subsection (c).

(f) A reasonable return on equity capital invested and used in the provisions of hospital care and services shall be an allowable cost of proprietory hospitals. The equity factor will be applied to equity capital which is calculated as the equity capital at the end of the base year as adjusted for allowable cost.

(g) Interest expense in excess of interest income shall be an allowable cost.

(h) Administrative and general cost in excess of miscellaneous income shall be an allowable cost.

(i) Overhead expenses shall be allocated to non-patient service such as gift shops and fund raising.

(j) Costs for consultants shall be amortized over the useful life of the asset that consultant work is related to, and the amortized cost shall be an allowable cost as set forth in RSC Reg. 71-33, § 3.

(k) Payments to professional organizations, trade associations and the like, and comprehensive health planning agencies shall be allowed as set forth in RSC Reg. 71-33, § 7.

s 3.56 *Excluded Costs*

The following costs are excluded under this part:

(a) Costs for whole blood, appliances, and patient take home items.

(b) The nursing service differential provided under 42 U.S.C. §§ 1395 *et seq.* and regulations adopted pursuant to that act.

(c) Bad debts, charity, courtesy allowances, and free care to medically indigent persons.

(d) Salaries, fees, commissions, or others compensation paid for services for which payment is made in whole or part as fee for service by third party payors or self insured persons.

Subpart F — Rate Determination, Inpatient Per Diem Rate

Sec.

3.61 Inpatient Per Diem Rate
3.62

s 3.61 *Inpatient Per Diem Rate*

The inpatient per diem rate for maternity and non maternity health care and services shall be calculated as follows:

(a) Determine base year inpatient operating cost as adjusted pursuant to subpart E.

(b) Determine rate year inpatient operating cost.

(c) Determine base year non operating cost as adjusted pursuant to subpart E.

(d) Determine total base year hospital cost.

(e) Determine the loading factor.

(f) Determine rate year inpatient non operating cost.

(g) Determine allowed inpatient days.

(h) The inpatient per diem rate is the mathematical sum of rate year inpatient operating cost and rate year inpatient non operating cost divided by allowed patient days.

$$\text{Inpatient per diem rate} = \frac{\text{rate year inpatient operating cost} + \text{rate year} = \text{inpatient non operating cost}}{\text{allowed inpatient days}}$$

Subpart G — Rate Determination, Well Newborn Per Diem Rate

Sec.

3.63 Well Newborn Per Diem Rate
3.64

s 3.63 *Well Newborn Per Diem Rate*

The well newborn inpatient per diem rate shall be one third of the inpatient per diem rate calculated under section 3.61.

Well newborn per diem rate = 1/3 x inpatient per diem rate

Subpart H — Rate Determination, Outpatient Rates

Sec.

3.65 Outpatient Rates
3.66 Change in Outpatient Charges
3.67 Approval of Change in Outpatient Charges
3.68

s 3.65 *Outpatient Rates*

The outpatient rate to be applied to each outpatient charge filed with the Commission pursuant to section 3.46 and ap-

proved by the Commission pursuant to section 3.67 shall be the outpatient cost to charge ratio, not to exceed 100%. The outpatient rate shall be further limited by the requirements of Chapter 424 of the Acts of 1975.

s 3.66 *Change in Outpatient Charges*

Submission for approval of any change in outpatient charges or any charge for new outpatient services shall be governed by the requirements of 14 CHSR 4.

s 3.67 *Approval of Change in Outpatient Charges*

Approval of a change in outpatient charges or a charge for new outpatient services shall be governed by the standards, requirements, and cost to charge ratio limits set forth in 14 CHSR 4.

Subpart I — Rate Determination, New Hospital

Sec.

3.69 New Hospital Rates
3.70

s 3.69 *New Hospital Rates*

The inpatient and well newborn per diem rates and the outpatient rates of a new hospital shall be calculated from its proposed hospital budget and projected volume and revenue data for the rate year and pursuant to subparts E, F, G, H insofar as these can be applied practically to the proposed hospital budget and volume and revenue data.

Subpart J — Rate Determination, Chronic Care

Sec.

3.71 Chronic Care Inpatient Rate Determination
3.72 Long Term Care Facility Rate Determination

s 3.71 *Chronic Care Inpatient Rate Determination*

In the case of Joseph P. Kennedy Memorial Hospital, Grover Manor Hospital, Milford-Whitinsville Regional Hospital, Wing Memorial Hospital, University Hospital and The Medical Center of Western Massachusetts, the Commission will segregate chronic care costs and will set chronic care inpatient rates by applying these segregated costs to the inpatient rate determination system set forth in Subpart F.

s 3.72 *Long Term Care Facility Rate Determination*

In the case of a hospital which operates a long term care facility licensed pursuant to G.L.c.111, § 71, the Commission will require segregation of hospital costs from long term care facility costs. The Commission will set a per diem rate for each hospital operated long term care facility pursuant to the requirements of RSC Reg. 75-4 and its successor parts.

Subpart K — Administrative Adjustment

Sec.

3.73 Purpose of Administrative Adjustment
3.74 Submission for Administrative Adjustment
3.75 Administrative Adjustment Decision

s 3.73 *Purpose of Administrative Adjustment*

A hospital may make application for discretionary administrative adjustment of an inpatient, well newborn, or outpatient rate for any of the following reasons:

(a) There has been a mechanical or clerical error in calculation of a rate approved under this part.

(b) Statutory or regulatory requirements of a governmental unit or the federal government have generated a substantial increase in allowable costs as adjusted pursuant to subpart E during the intermediate or rate year.

(c) There has been a transfer of ownership of a hospital to an unrelated party or entity, at arm's length, and for good and valuable consideration at a reasonable price during the intermediate or rate year. Any adjustment to allowable cost as adjusted pursuant to subpart E will be limited to reasonable increase of base year non operating costs resulting directly from the transfer of ownership.

(d) There has been an extraordinary increase in operating costs beyond the reasonable control of a hospital during the intermediate or rate year which is not reflected in the inflation factor and which gravely threatens the financial stability of the hospital.

(e) A hospital has incurred or expects to incur a substantial capital expenditure or has made or expects to make a substantial change in services during the intermediate or rate year which is subject to a determination of need pursuant to G.L.c.111, §§ 25B-25G. Except upon request of the Commissioner of Public Health, an application for administrative adjustment in this situation shall be made after the Department of Public Health has determined that need exists for the capital expenditure or change in services.

(f) A hospital had undertaken a substantial new service during the intermediate year which has generated additional annual operating costs in excess of $100,000 and which is not subject to a determination of need. The application for administrative adjustment must demonstrate that the new service does not duplicate existing services within the geographic service area of the hospital and that the new service is necessary to provide adequate care and services to the general public served by the hospital based upon population characteristics, disease incidence, projected utilization, inaccessability of similar service, and a determination by the regional health planning agency that it concurs in the hospital's judgment of need.

(g) A hospital cannot use a significant portion of its licensed beds during a substantial period of time for cause other than underutilization by the general public within the geographic service area of the hospital, scheduled refurbishing, seasonal utilization patterns, or the like and such that use of licensed beds in the calculation of available bed days would be patently inequitable.

(h) A hospital has increased costs reported for the base year by adding to its payroll for a particular department compensation paid to physicians who previously billed patients directly, provided that with respect to such department, no physicians were compensated by the hospital in the base year and all physicians are to be compensated in full in the rate year by the hospital.

s 3.74 *Submission for Administrative Adjustment*

An application for administrative adjustment shall be made to the chairman of the Commission in writing and shall contain the following:

(a) The name and address of the hospital.

(b) The approved inpatient, outpatient, or well newborn rate to be reviewed and the rate sought by administrative adjustment.

(c) A clear, concise statement of the reasons for the application for administrative adjustment.

(d) A detailed statement of financial, statistical, and related information in support of the application.

(e) All information and documentation required under section 3.46.

(f) A citation to any statutory, regulatory, or contractual requirement in support of the application.

(g) Such other books, records, and information as may be required by the Commission.

(h) A certification by the chief executive officer or financial officer of the hospital that the application and all information, reports, schedules, budgets, books, and records submitted are true, correct, and accurate.

s 3.75 *Administrative Adjustment Decision*

Within 60 days from receipt of a complete and satisfactory application for administrative adjustment, the Commission will render a decision. A written statement of reasons for the decision will be provided upon request.

Subpart L — Administrative Review

Sec.

3.76 Purpose of Administrative Review
3.77 Administrative Review of Transfer of Cost
3.78 Administrative Review and Decision

s 3.76 *Purpose of Administrative Review*

To assure that an approved inpatient, outpatient, or well newborn rate is adequate and appropriate, the Commission may, at any time and upon its own motion, review an approved rate upon notice to the hospital.

s 3.77 *Administrative Review of Transfer of Cost*

Where a hospital has reduced costs reported for the base year by elimination or transfer of those costs to other persons

or entities which provide health care and services, the Commission may reduce the approved inpatient, well newborn, or outpatient rate to reflect the reduced costs.

s 3.78 *Administrative Review and Decision*

Upon notice of administrative review, a hospital shall submit such books, records, documentation, and information as the Commission any require. After review, the Commission will render a written decision and statement of reasons for its decision. The decision may include an increase, decrease, or maintenance of rate.

Subpart M — Appeal

Sec.

3.79 Appeal
3.80

s 3.79 *Appeal*

A hospital which is aggrieved by any action or failure to act under this part may file an appeal within 30 days to the Division of Hearings Officers pursuant to the requirements of G.L.c.6A, § 36, c.7, § 4H. The pendency of an appeal does not limit the Commission's right to undertake administrative review of a rate approved under this part.

Subpart N — Administrative Information Bulletin

Sec.

3.80 Purpose of Administrative Information Bulletins
3.81 Administrative Information Bulletins Issued under RSC Reg. 74-26

s 3.80 *Purpose of Administrative Information Bulletins*

The Commission may, from time to time, issue administrative information bulletins to clarify its policy upon and understanding of substantive provisions of this part. In addition, the Commission may issue administrative information bulletins which specify the information and documentation necessary to implement this part or necessary for informed consideration of rate requests, rate adjustments, and rate review under this part.

s 3.81 *Administrative Information Bulletins Issued under RSC Reg. 74-26*

The following Administrative Information Bulletins issued under RSC Reg. 74-26 are adopted under this subpart: 74-26-4; 74-26-5; 74-26-8; 74-26-9. These bulletins are to be applied as appropriate to the requirements of this part.

Subpart O — Rate Filings

Sec.

3.82 Rate Filings
3.83
3.84
3.85
3.86
3.87

s 3.82 *Rate Filings*

Inpatient, outpatient, and well newborn rates determined and approved under this part shall be filed with the Secretary of the Commonwealth under this subpart.

Subpart P — Hospital Statement for Reimbursement

Sec.

3.88 Hospital Statement for Reimbursement, RSC 401, RSC 401A
3.89
3.90

s 3.88 *Hospital Statement for Reimbursement, RSC 401, RSC 401A*

The RSC 401, RSC 401A, and schedules and instructions referenced in subpart E are incorporated in this section.

Appendix F.

THE COMMONWEALTH OF MASSACHUSETTS
RATE SETTING COMMISSION
One Ashburton Place, Boston, Mass. 02108
Area Code (617) 727-1150

October 8, 1976

The Honorable Paul H. Guzzi
Secretary of the Commonwealth
State House
Boston, Massachusetts

Dear Mr. Secretary:

At its meeting of September 30, 1976, the Rate Setting Commission found that immediate adoption of a certain amendment to 14 CHSR 3 is necessary for preservation of public health and general welfare pursuant to G.L. c. 30A, s 2 and that observance of the usual requirements of prior notice and opportunity to be heard would be contrary to those interests.

In particular, the Commission found that immediate adoption of amended part 3 is necessary to advise hospitals of their rates effective October 1, 1976. Therefore, the Commission has voted that an emergency exists and that the amended section of 14 CHSR 3 should be adopted immediately.

A copy of 14 CHSR 3 as amended is enclosed for filing pursuant to G.L. c. 30, s 37. This letter should be incorporated in the regulation as the Commission's finding and statement of reasons pursuant to G.L. c. 30A, s 2.

Very truly yours,

JOHN A. DALEY,
Executive Secretary

TITLE 14 — RATE SETTING COMMISSION

CHAPTER I — BUREAU OF HOSPITALS AND CLINICS

Part 3 — Prospective Inpatient, Outpatient and Well-Newborn Rate Determination

List of Sections Affected

Added . . . . . September 30, 1976

Numbering Revised

s3.09,s3.10,s3.11,s3.12,s3.13,s3.14,s3.15,s3.74,s3.75, s3.76,s3.77,s3.78,s3.80,s3.80,s3.81,s3.82,s3.83 and s3.90.

Other Revisions

s3.01 *Scope, Purpose and Effective Date* — amendment to incorporate 14 CHSR 7 and to revise dates
s3.02 *Disclaimer of Authorization of Services* — amendment to incorporate 14 CHSR 7
s3.03 *Care Included under this Part* — amendment to incorporate 14 CHSR 7
s3.18 *RSC 100* — amended to substitute definition of the RSC 100 for the obsolete HFC 400
s3.19 *RSC 401* — technical amendment to make applicable to the current rate year
s3.20 *Base Year* — technical amendment to make applicable to the current rate year
s3.21 *Intermediate Year* — technical amendment to make applicable to the current rate year
s3.22 *Rate Year* — technical amendment to make applicable to the current rate year

s3.23 *Equity Factor* — amendment to alter percentage
s3.24 *Inflation Factor* — amendment to alter percentage
s3.25 *Known Adjustment* — technical amendment to reference current reporting forms
s3.27 *Base Year Non Operating Cost* — technical amendment to reference current reporting forms
s3.29 *Base Year Inpatient Operating Cost* — technical amendment to reference current reporting forms
s3.30 *Base Year Ambulatory Service Cost* — technical amendment to reference current reporting forms
s3.31 *Base Year Non Patient Expense* — technical amendment to reference current reporting forms
s3.42 *Total Base Year Outpatient Charges* — technical amendment to reference current reporting forms
s3.46 *Required Reports and Records* — technical amendment to reference current reporting forms and to consolidate subsections
s3.47 *Filing Dates* — technical amendment to make applicable to the current rate year and to reference current reporting forms
s3.51 *Reimbursement as Full Payment* — amendment to incorporate 14 CHSR 7
s3.52 *Inpatient, Well-Newborn Rate Limitation* — technical amendment to make applicable to the current rate year
s3.54 *Adjustments to Hospital Cost Reports* — technical amendment to reference current reporting forms
s3.55 *Allowable Cost* — technical amendment to reference current reporting forms
s3.66 *Change in Outpatient Charges* — technical amendment to reference current reporting forms
s3.67 *Approval of Change in Outpatient Charges* — technical amendment to reference current reporting forms

s3.72 *Long Term Care Facility Rate Determination* — technical amendment to reference current reporting forms
s3.73 *Life Sustaining Drugs and Medications Rate Determination* — added to incorporate 14 CHSR 7
s3.79 *Administrative Review of the Inflation Factor* — added to provide for administrative review of the inflation factor
s3.83 *Administrative Information Bulletins Issued under RSC Reg. 74-26* — technical amendment to reference current information bulletins
s3.84 *Rate Filings for Acute Care Hospitals* — amended to reference calculations for the current rate year
s3.85 *Rate Filings for Life Sustaining Drugs and Medications* — added to incorporate rates previously calculated under 14 CHSR 7
s3.86 *Rate Filings for Chronic and Other Care Institutions* — amended to reference calculations for the current rate year
s3.87 *Rate Filings for Public Medical Institutions and Infirmaries* — amended to reference calculations for the current rate year
s3.90 *Hospital Statement for Reimbursement, RSC 100, RSC 401, RSC 401A* — technical amendment to reference current reporting forms

TITLE 14 — RATE SETTING COMMISSION

CHAPTER I — BUREAU OF HOSPITALS AND CLINICS

Part 3 — Prospective Inpatient, Outpatient and Well-Newborn Rate Determination

(as amended September 30, 1976)

Subpart A — General Provisions

Sec.

3.01 Scope, Purpose, and Effective Date
3.02 Disclaimer of Authorization of Services
3.03 Care Included under this Part
3.04 Authority

s 3.01 *Scope, Purpose, and Effective Date* (Rev. 9/30/76)

This part governs:

(a) Prospective rates of payment for inpatient, outpatient, and well-newborn hospital care and services provided to publicly aided individuals during the rate year from October 1, 1976 through September 30, 1977.

(b) Prospective rates of payment for the provisions of life sustaining drugs and medications by hospitals to general relief patients pursuant to Chapter VII of the Massachusetts Public Assistance Policy Manual, section J, part 5, during the rate year from October 1, 1976 through September 30, 1977.

This part shall be effective from the date of its publication by the Secretary of the Commonwealth.

s 3.02 *Disclaimer and Authorization of Services* (Rev. 9/30/76)

This part is not an authorization for or approval of the substantive program of hospital care and services or of the

substantive program set forth in Chapter VII of the Massachusetts Public Assistance Policy Manual, section J, part 5, for which rates are set by this part. Governmental units which make payments under this part are responsible for the definition, authorization and approval of such substantive programs.

s 3.03 *Care Included under this Part* (Rev. 9/30/76)

Rates of payment under this part shall include:

(a) Payment for all inpatient, outpatient, and well-newborn hospital care and services which are provided by a hospital to publicly aided individuals, subject to an agreement for hospital care and services between the hospitals and governmental unit.

(b) Payment for life sustaining drugs and medications which are provided by a hospital to general relief patients, subject to the requirements of Chapter VII of the Massachusetts Public Assistance Policy Manual, section J, part 5 and the Department of Public Welfare.

s 3.04 *Authority*

This part is adopted pursuant to G.L.c.6A, §§ 31-36. This citation of authority conforms to 1 CHSR 26.45.

s 3.13 *Prudent Buyer Concept* (numbering Rev. 9/30/76)

An assumption that any amount paid for goods and services which is in excess of the fair market price or the amount paid by comparable hospitals is unreasonable.

s 3.14 *Publicly Aided Individual* (numbering Rev. 9/30/76)

A person who receives hospital care and services for which a governmental unit is in whole or part liable under a statutory program of public assistance.

s 3.15 *Teaching Hospital* (numbering Rev. 9/30/76)

A hospital which maintains accredited teaching programs as listed in the *Directory of Approved Internships and Residencies of the American Medical Association.*

Subpart C — Rate Determination Definitions

Sec.

3.16 Meaning of Terms
3.17 Reasonable Cost
3.18 RSC 100
3.19 RSC 401
3.20 Base Year
3.21 Intermediate Year
3.22 Rate Year
3.23 Equity Factor
3.24 Inflation Factor
3.25 Known Adjustment
3.26 Loading Factor
3.27 Base Year Non Operating Cost
3.28 Total Base Year Hospital Cost
3.29 Base Year Inpatient Operating Cost
3.30 Base Year Ambulatory Service Cost
3.31 Base Year Non Patient Expense
3.32 Allowed Inpatient Days
3.33 Maternity Inpatient Days
3.34 Adjusted Maternity Inpatient Days
3.35 Adjusted Newborn Inpatient Days
3.36 Non Maternity Inpatient Days
3.37 Adjusted Non Maternity Inpatient Days
3.38 Available Bed Days
3.39 Rate Year Inpatient Non Operating Cost
3.40 Rate Year Inpatient Operating Cost

3.41 Outpatient Cost to Charge Ratio
3.42 Total Base Year Outpatient Charges
3.43
3.44
3.45

s 3.16 *Meaning of Terms*

As used in this part, unless the context requires otherwise, terms shall have the meanings ascribed in this subpart.

s 3.17 *Reasonable Cost*

A cost incurred by a hospital in providing hospital care and services, provided that such cost is necessary, comparable to the cost of providing similar care and services and consistent with the prudent buyer concept.

s 3.18 *RSC 100* (Rev. 9/30/76)

The hospital statement for reimbursement which is filed with the Commission by certain hospitals designated by the Commission in which no cost allocations are necessary because of the relatively small size of the hospital and the uniformity of services provided.

s 3.19 *RSC 401* (Rev. 9/30/76)

The hospital statement for reimbursement which is filed with the Commission for the base year or intermediate year and which is completed in accord with the requirements of this part.

s 3.20 *Base Year* (Rev. 9/30/76)

The hospital fiscal year ending September 30, 1975. In the case of municipal hospitals, the base year shall be the fiscal year ending June 30, 1975.

s 3.21 *Intermediate Year* (Rev. 9/30/76)

The hospital fiscal year ending September 30, 1976. In the case of municipal hospitals, the intermediate year shall be the fiscal year ending June 30, 1976.

s 3.22 *Rate Year* (Rev. 9/30/76)

The period from October 1, 1976 through September 30, 1977.

s 3.23 *Equity Factor* (Rev. 9/30/76)

11.08% of equity capital invested and used in the provision of hospital care and services by a proprietary hospital during the base year.

s 3.24 *Inflation Factor* (Rev. 9/30/76)

A rate of 6% per year which represents the reasonable change in inpatient operating costs for inflation from the intermediate year through the rate year.

s 3.25 *Known Adjustment* (Rev. 9/30/76)

An adjustment pursuant to subpart E which is made to an unaudited RSC 401 or RSC 100, which involves correction of a mathematical error, reallocation of an historically recurring cost to the appropriate cost category, or rejection of a cost which is not reimbursed under this part.

s 3.26 *Loading Factor*

The quotient of base year non operating cost as adjusted pursuant to subpart E divided by total base year hospital cost.

s 3.27 *Base Year Non Operating Cost* (Rev. 9/30/76)

The non operating cost reported by a hospital for the base year, set forth in RSC 100 or in Schedule V-E of RSC 401.

s 3.28 *Total Base Year Hospital Cost*

The sum of base year inpatient operating cost, base year ambulatory service cost, and base year non patient expense, all as adjusted pursuant to subpart E.

s 3.29 *Base Year Inpatient Operating Cost* (Rev. 9/30/76)

The inpatient operating cost reported by a hospital for the base year, set forth in RSC 100 or in Schedule VI of RSC 401.

s 3.30 *Base Year Ambulatory Service Cost* (Rev. 9/30/76)

The ambulatory service cost reported by a hospital for the base year, set forth in Schedule VI of RSC 401.

s 3.31 *Base Year Non Patient Expense* (Rev. 9/30/76)

The non patient expense reported by a hospital for the base year, set forth in RSC 100 or in Schedule VI of RSC 401.

s 3.32 *Allowed Inpatient Days*

The sum of adjusted maternity inpatient days, adjusted newborn inpatient days, and adjusted non maternity inpatient days.

s 3.33 *Maternity Inpatient Days*

Actual maternity inpatient days for the base year. In the case of a hospital which uses maternity beds for gynecology patients, maternity inpatient days shall be the sum of actual maternity inpatient days for the base year plus actual gynecology inpatient days generated from use of maternity beds for the base year.

s 3.34 *Adjusted Maternity Inpatient Days*

The higher of maternity inpatient days in the base year or 60% of the total number of maternity available bed days in the base year. In the case of Nantucket Cottage Hospital and Martha's Vineyard Hospital, adjusted maternity inpatient days shall be actual maternity inpatient days.

s 3.35 *Adjusted Newborn Inpatient Days*

One third of the actual well-newborn inpatient days for the base year.

s 3.36 *Non Maternity Inpatient Days*

Actual inpatient days for the base year for all inpatients other than maternity and well-newborn inpatients.

s 3.37 *Adjusted Non Maternity Inpatient Days*

The higher of non maternity inpatient days or 75% of the total number of non maternity available bed days in the base year or 80% of the total number of non maternity available bed days in the base year in the case of those teaching hospitals denoted in section 3.15.

s 3.38 *Available Bed Days*

The product of the number of beds licensed by the Department of Public Health during the base year and the number of calendar days in the base year.

s 3.39 *Rate Year Inpatient Non Operating Cost*

The product of base year inpatient operating cost as adjusted pursuant to subpart E multiplied by the loading factor.

s 3.40 *Rate Year Inpatient Operating Cost*

The base year inpatient operating cost as adjusted pursuant to subpart E and as projected through the rate year by the inflation factor.

s 3.41 *Outpatient Cost to Charge Ratio*

The ratio, expressed as a percentage:

$$\frac{\text{(base year ambulatory service cost as adjusted pursuant to subpart E x loading factor)}}{\text{(total base year outpatient charges as adjusted pursuant to subpart E and as allowed pursuant to subpart H)}}$$

s 3.42 *Total Base Year Outpatient Charges* (Rev. 9/30/76)

Gross ambulatory service charges for the base year as reported on Schedule II of RSC 401.

Subpart D — Filing and Reporting Requirements

Sec.

3.46 Required Reports and Records
3.47 Filing Dates
3.48 Penalty for Late or Inadequate Filing
3.49
3.50

s 3.46 *Required Reports and Records* (Rev. 9/30/76)

(a) Each hospital shall file the RSC 100, RSC 401, or RSC 401A, as required, and appropriate schedules. These reports are to be completed in accord with the instructions set forth therein; in accord with generally accepted accounting principles; and pursuant to requirements of RSC Reg. 71-33, administrative information bulletins of RSC Reg. 74-26, and this part. Copies of these reports, schedules, and instructions are incorporated herein and are annexed hereto.

(b) Each hospital shall file a proposed hospital budget and projected volume and revenue data for the rate year in such form and content as the Commission may require.

(c) Each hospital shall file a copy of its three year capital expenditure budget which is required under 42 U.S.C. §§ 1395 *et seq.*, the medicare act.

(d) Each hospital shall file a complete schedule of all outpatient charges and shall amend that schedule as outpatient charges are changed during the rate year.

(e) Each hospital shall comply with the filing and reporting requirements of RSC Reg. 71-33, §§ 2, 3, 7 in regard to fees, salaries, commissions, or any other remuneration paid for services for which payment is made in whole or part by third party payors or self insured persons; consultant contracts; and payments to professional organizations, trade associations, and the like. The physician service form, PS-1, must be filed for each physician who is a member of the medical staff.

(f) Each hospital shall notify the Commission in writing of any transfer of costs as set forth in section 3.78.

(g) Each hospital shall file its credit and collection plan and free service plan with the Commission.

(h) Each hospital shall file such additional information as the Commission may from time to time require.

(i) Each hospital shall make available all books and records relating to its operation and its program of hospital care and services.

(j) All reports, schedules, budgets, information, books, and records which are filed with or made available to the Commission shall be certified as true, correct, and accurate by the chief executive officer or financial officer of the hospital.

(k) A hospital which fails or refuses to file or make available required reports, schedules, budgets, information, books, and records shall forego determination and further certification of rates for its hospital care and services.

s 3.47 *Filing Dates* (Rev. 9/30/76)

(a) The RSC 401 for the fiscal year ending September 30, 1976 or the fiscal year ending June 30, 1976 in the case of municipal hospitals and the three year capital expenditure budget shall be filed within 90 days from October 1.

(b) The RSC 401 for the fiscal year ending September 30, 1977 or the fiscal year ending June 30, 1977 in the case of municipal hospitals and the three year capital expenditure budget shall be filed within 90 days from the close of the fiscal year. The RSC 100 shall be filed within 45 days from the close of the 1976 fiscal year.

(c) RSC 401A shall be filed within 45 days from the close of the quarter for each quarter of the rate year or each quarter after June 30, 1976 in the case of municipal hospitals.

(d) The credit and collection plan and free service plan shall be filed with and at the same time that RSC 401 is filed. Amendments to these plans shall be filed not later than 60 days prior to the proposed effective date.

(e) Each new hospital shall file a proposed hospital budget and projected volume and revenue data for the rate year not later than 60 days prior to beginning patient care.

(f) Each hospital shall file a complete schedule of all current outpatient charges on the first day of the rate year. Amendments to this schedule shall be filed 60 days prior to the effective date of proposed change to the schedule of all outpatient charges. Filing of outpatient charges pursuant to 14 CHSR 9 shall satisfy the requirement of this subsection.

(g) Each hospital shall file the information and reports required by RSC Reg. 71-33, §§ 2, 3, 7 within 90 days from the close of the fiscal year. Amendments to these reports and information shall be filed within 45 days from the date of changed circumstances.

(h) Each hospital shall file a report of any transfer of cost as set forth in section 3.78 within 7 days of that transfer.

(i) All other information shall be filed within 30 days from the date of request unless a different time limit is set forth in the request.

(j) The chairman of the Commission may, for cause, extend the filing date for submission of reports, schedules, budgets, information, books, and records.

s 3.48 *Penalty for Late or Inadequate Filing*

Where there has been a late or inadequate filing of required reports, schedules, budgets, information, books, and records, the Commission may determine an effective date for the rates determined under this part which reflects the time lost by late or inadequate filing.

Subpart E — Rate Determination, General Provisions

Sec.

3.51 Reimbursement as Full Payment
3.52 Inpatient, Well Newborn Rate Limitation
3.53 Outpatient Rate Limitation
3.54 Adjustments to Hospital Costs Reports
3.55 Allowable Cost
3.56 Excluded Cost
3.57
3.58
3.59
3.60

s 3.51 *Reimbursement as Full Payment* (Rev. 9/30/76)

Reimbursement or payment by governmental units for care and services or for life sustaining drugs and medications purchased from hospitals shall be determined in accord with the provisions of this part, and each hospital which provides hospital care and services or life sustaining drugs and medications shall, as a condition to receipt of such reimbursement or payment, accept reimbursement at rates established by this Commission, subject to appellate rights set forth in G.L. c. 6A, § 36, as full payment and discharge of all obligations of publicly aided individuals for the care and services or life sustaining drugs and medications purchased under this part. There shall be no duplication or supplementation of payment.

s 3.52 *Inpatient, Well-Newborn Rate Limitation*

(a) Inpatient and well-newborn rates determined under this part for a hospital will not exceed that reimbursement or payment which would result from application of the Principles of Reimbursement for Provider Costs established under 42 U.S.C. §§ 1395, *et seq.*, the medicare act.

(b) Inpatient rates determined under this part for a hospital will not exceed its charges to the general public for the same care and services. For purposes of this section, a hospital's charges to the general public for inpatient care and services shall be imputed in accordance with the formula:

$$\text{average semi private room and board charge intended to be effective on October 1, 1975 and as approved pursuant to Chapter 424 of the Acts of 1975 and 14 CHSR 9} + \left(\frac{\text{total gross special service charges for adults and children for the base year}}{\text{maternity and non maternity days for the base year}} + \frac{\text{total gross special service charges for well-newborn for the base year}}{\text{one third of the well newborn days for the base year}} \right) \times \text{inflation factor}$$

(c) Well-newborn rates determined under this part for a hospital will not exceed its charges to the general public for the same care and services. For purposes of this section, a hospital's charges to the general public for well-newborn care and services shall be one third of the imputed charge set forth in subsection (b).

s 3.53 *Outpatient Rate Limitation*

(a) Outpatient rates determined under this part shall not exceed that reimbursement or payment which would result from application of the Principles of Reimbursement for Provider Costs established under 42 U.S.C. §§ 1395 *et seq.*, the medicare act.

(b) Outpatient rates determined under this part will not exceed the rates payable to a hospital by any third party payor.

(c) Outpatient rates determined under this part will not exceed charges to the general public as approved pursuant to Chapter 424 of the Acts of 1975.

s 3.54 *Adjustments to Hospital Cost Reports* (Rev. 9/30/76)

Rates determined under this part shall be calculated from audited and adjusted RSC 100 or RSC 401 statements when possible. Audited RSC 100 or RSC 401 statements will be adjusted to reflect allowable cost and to reject excluded costs. Unaudited RSC 100 or RSC 401 statements from which rates are calculated under this part will be adjusted through the use of known adjustments to reflect allowable cost and to reject excluded costs.

s 3.55 *Allowable Cost* (Rev. 9/30/76)

(a) Pursuant to the requirements and rate determination formulas of this part, hospitals will be reimbursed for

allowable costs. These costs must be reasonable costs and must be directly related to hospital care and services.

(b) Except as otherwise required in this part and the instructions to RSC 100 or to RSC 401, allowable costs for inpatient, outpatient, and well-newborn hospital care and services shall be determined in accord with the Principles of Reimbursement for Provider Costs under 42 U.S.C. §§ 1395 *et seq.* as set forth in 20 CFR 405, *et seq.* and the *Provider Reimbursement Manual.*

(c) Depreciation shall be an allowable cost provided that it is based on historical cost and is calculated by the straight line method. The useful life of an asset shall be determined in accordance with section 1 of the *Handbook on Accounting, Statistics, and Business Office Procedures for Hospitals* (Publication M10-50, American Hospital Association, 1950).

(d) Costs for leased facilities and fixed equipment shall be an allowable cost to the extent that such costs do not exceed the allowable cost which would have been recognized if the hospital had purchased the equipment or facilities and to the extent that such costs do not exceed rental charges of comparable equipment or facilities.

(e) Costs for equipment and facilities leased under contractual provisions which provide a purchase option at the end of the lease term without more than nominal payment will not be allowed. Depreciation will be allowed pursuant to subsection (c).

(f) A reasonable return on equity capital invested and used in the provisions of hospital care and services shall be an allowable cost of proprietory hospitals. The equity factor will be applied to equity capital which is calculated as the equity capital at the end of the base year as adjusted for allowable cost.

(g) Interest expense in excess of interest income shall be an allowable cost.

(h) Administrative and general cost in excess of miscellaneous income shall be an allowable cost.

(i) Overhead expenses shall be allocated to non patient service such as gift shops and fund raising.

(j) Costs for consultants shall be amortized over the useful life of the asset that consultant work is related to, and the amortized cost shall be an allowable cost as set forth in RSC Reg. 71-33, § 3.

(k) Payments to professional organizations, trade associations and the like, and comprehensive health planning agencies shall be allowed as set forth in RSC Reg. 71-33, § 7.

s 3.56 *Excluded Costs*

The following costs are excluded under this part:

(a) Costs for whole blood, appliances, and patient take home items.

(b) The nursing service differential provided under 42 U.S.C. §§ 1395 *et seq.* and regulations adopted pursuant to that act.

(c) Bad debts, charity, courtesy allowances, and free care to medically indigent persons.

(d) Salaries, fees, commissions, or other compensation paid for services for which payment is made in whole or part as fee for service by third party payors or self insured persons.

Subpart F — Rate Determination, Inpatient Per Diem Rate

Sec.

3.61 Inpatient Per Diem Rate
3.62

s 3.61 *Inpatient Per Diem Rate*

The inpatient per diem rate for maternity and non maternity health care and services shall be calculated as follows:

(a) Determine base year inpatient operating cost as adjusted pursuant to subpart E.

(b) Determine rate year inpatient operating cost.

(c) Determine base year non operating cost as adjusted pursuant to subpart E.

(d) Determine total base year hospital cost.

(e) Determine the loading factor.

(f) Determine rate year inpatient non operating cost.

(g) Determine allowed inpatient days.

(h) The inpatient per diem rate is the mathematical sum of rate year inpatient operating cost and rate year inpatient non operating cost divided by allowed patient days.

$$\text{Inpatient per diem rate} = \frac{\text{rate year inpatient operating cost} + \text{rate year inpatient non operating cost}}{\text{allowed inpatient days}}$$

Subpart G — Rate Determination, Well-Newborn Per Diem Rate

Sec.

3.63 Well-Newborn Per Diem Rate
3.64

s 3.63 *Well-Newborn Per Diem Rate*

The well-newborn inpatient per diem rate shall be one third of the inpatient per diem rate calculated under section 3.61.

Well-newborn per diem rate = 1/3 x inpatient per diem rate

Subpart H — Rate Determination, Outpatient Rates

Sec.

3.65 Outpatient Rates

3.66 Change in Outpatient Charges
3.67 Approval of Change in Outpatient Charges
3.68

s 3.65 *Outpatient Rates*

The outpatient rate to be applied to each outpatient charge filed with the Commission pursuant to section 3.46 and approved by the Commission pursuant to section 3.67 shall be the outpatient cost to charge ratio, not to exceed 100%. The outpatient rate shall be further limited by the requirements of Chapter 424 of the Acts of 1975.

s 3.66 *Change in Outpatient Charges* (Rev. 9/30/76)

Submission for approval of any change in outpatient charges or any charge for new outpatient services shall be governed by the requirements of 14 CHSR 9.

s 3.67 *Approval of Change in Outpatient Charges* (Rev. 9/30/76)

Approval of a change in outpatient charges or a charge for new outpatient services shall be governed by the standards, requirements, and cost to charge ratio limits set forth in 14 CHSR 9.

Subpart I — Rate Determination, New Hospital

Sec.

3.69 New Hospital Rates
3.70

s 3.69 *New Hospital Rates*

The inpatient and well-newborn per diem rates and the outpatient rates of a new hospital shall be calculated from its proposed hospital budget and projected volume and revenue data for the rate year and pursuant to subparts E, F, G, H insofar as these can be applied practically to the proposed hospital budget and volume and revenue data.

Subpart J — Rate Determination, Chronic Care

Sec.

3.71 Chronic Care Inpatient Rate Determination
3.72 Long Term Care Facility Rate Determination

s 3.71 *Chronic Care Inpatient Rate Determination*

In the case of Joseph P. Kennedy Memorial Hospital, Grover Manor Hospital, Milford-Whitinsville Regional Hospital, Wing Memorial Hospital, University Hospital and The Baystate Medical Center, the Commission will segregate chronic care costs and will set chronic care inpatient rates by applying these segregated costs to the inpatient rate determination system set forth in Subpart F.

s 3.72 *Long Term Care Facility Rate Determination* (Rev. 9/30/76)

In the case of a hospital which operates a long term care facility licensed pursuant to G.L.c.111, § 71, the Commission will require segregation of hospital costs from long term care facility costs. The Commission will set a per diem rate for each hospital operated long term care facility pursuant to the requirements of 14 CHSR 201 or any successor parts.

Subpart K — Rate Determination, Life Sustaining Drugs and Medications

Sec.

3.73 Life Sustaining Drugs and Medications Rate Determination

3.73 *Life Sustaining Drugs and Medications Rate Determination* (added 9/30/76)

The rate to be paid to a hospital for life sustaining drugs and medications shall be calculated as a percentage, not to exceed 100%, of current charges approved under Chapter 424 of the Acts of 1975, as amended, and 14 CHSR 9. This percentage is to be derived under the following formula:

$$\frac{\text{In-Patient Pharmacy Cost from schedule VI, RSC 401}}{\text{In-Patient Pharmacy Charges from schedule II, RSC 401}} \times (100\% + \text{Loading Factor derived from schedule VII, RSC 401})$$

Subpart L — Administrative Adjustment

Sec.

s 3.74 Purpose of Administrative Adjustment
s 3.75 Submission for Administrative Adjustment
s 3.76 Administrative Adjustment Decision

s 3.74 *Purpose of Administrative Adjustment* (numbering 9/30/76)

A hospital may make application for discretionary administrative adjustment of an inpatient, well-newborn, or outpatient rate for any of the following reasons:

(a) There has been a mechanical or clerical error in calculation of a rate approved under this part.

(b) Statutory or regulatory requirements of a governmental unit or the federal government have generated a substantial increase in allowable costs as adjusted pursuant to subpart E during the intermediate or rate year.

(c) There has been a transfer of ownership of a hospital to an unrelated party or entity, at arm's length, and for good and valuable consideration at a reasonable price during the intermediate or rate year. Any adjustment to allowable cost as adjusted pursuant to subpart E will be limited to reasonable increase of base year non operating costs resulting directly from the transfer of ownership.

(d) There has been an extraordinary increase in operating costs beyond the reasonable control of a hospital during the intermediate or rate year which is not reflected in the inflation factor and which gravely threatens the financial stability of the hospital.

(e) A hospital has incurred or expects to incur a substantial capital expenditure or has made or expects to make a substantial change in services during the intermediate or rate year which is subject to a determination of need pursuant to G.L.c.111, §§ 25B-25G. Except upon request of the Commissioner of Public Health, an application for administrative adjustment in this situation shall be made after the Department of Public Health has determined that need exists for the capital expenditure or change in services.

(f) A hospital had undertaken a substantial new service during the intermediate year which has generated additional annual operating costs in excess of $100,000 and which is not subject to a determination of need. The application for administrative adjustment must demonstrate that the new service does not duplicate existing services within the geographic service area of the hospital and that the new service is neces-

sary to provide adequate care and services to the general public served by the hospital based upon population characteristics, disease incidence, projected utilization, inaccessability of similar service, and a determination by the regional health planning agency that it concurs in the hospital's judgment of need.

(g) A hospital cannot use a significant portion of its licensed beds during a substantial period of time for cause other than underutilization by the general public within the geographic service area of the hospital, scheduled refurbishing, seasonal utilization patterns, or the like and such that use of licensed beds in the calculation of available bed days would be patently inequitable.

(h) A hospital has increased costs reported for the base year by adding to its payroll for a particular department compensation paid to physicians who previously billed patients directly, provided that with respect to such department, no physicians were compensated by the hospital in the base year and all physicians are to be compensated in full in the rate year by the hospital.

s 3.75 *Submission for Administrative Adjustment* (numbering Rev. 9/30/76)

An application for administrative adjustment shall be made to the chairman of the Commission in writing and shall contain the following:

(a) The name and address of the hospital.

(b) The approved inpatient, outpatient, or well-newborn rate to be reviwed and the rate sought by administrative adjustment.

(c) A clear, concise statement of the reasons for the application for administrative adjustment.

(d) A detailed statement of financial, statistical, and related information in support of the application.

(e) All information and documentation required under section 3.46.

(f) A citation to any statutory, regulatory, or contractual requirement in support of the application.

(g) Such other books, records, and information as may be required by the Commission.

(h) A certification by the chief executive officer or financial officer of the hospital that the application and all information, reports, schedules, budgets, books, and records submitted are true, correct, and accurate.

s 3.76 *Administrative Adjustment Decision* (numbering Rev. 9/30/76)

Within 60 days from receipt of a complete and satisfactory application for administrative adjustment, the Commission will render a decision. A written statement of reasons for the decision will be provided upon request.

Subpart M — Administrative Review

Sec.

3.77 Purpose of Administrative Review
3.78 Administrative Review of Transfer of Cost
3.79 Administrative Review of the Inflation Factor
3.80 Administrative Review and Decision

s 3.77 *Purpose of Administrative Review* (numbering Rev. 9/30/76)

To assure that an approved inpatient, outpatient, well-newborn or life sustaining drugs and medications rate is adequate and appropriate, the Commission may, at any time and upon its own motion, review an approved rate upon notice to the hospital.

s 3.78 *Administrative Review of Transfers of Cost* (numbering Rev. 9/30/76)

Where a hospital has reduced costs reported for the base year by elimination or transfer of those costs to other persons or entities which provide health care and services, the Commission may reduce the approved inpatient, well-newborn, or outpatient rate to reflect the reduced costs.

s 3.79 *Administrative Review of the Inflation Factor* (added 9/30/76)

Before the end of the rate year, the Commission may determine indicators to be applied to components of provider base year costs to measure the change in such costs by reference to changes in related cost categories experienced in the economy generally since the base year. If the application of such indicators produces an inflation factor substantially at variance from the initial inflation factor used under section 3.24, an appropriate adjustment may be made to reflect the difference between the rate as calculated using said initial inflation factor and the rate that would have been calculated had the initial inflation factor been equal to the inflation factor produced under this section.

s 3.80 *Administrative Review and Decision* (numbering Rev. 9/30/76)

Upon notice of administrative review, a hospital shall submit such books, records, documentation, and information as the Commission may require. After review, the Commission will render a written decision and statement of reasons for its decision. The decision may include an increase, decrease, or maintenance of rate.

Subpart N — Appeal

Sec.

3.81 Appeal

s 3.81 *Appeal* (numbering Rev. 9/30/76)

A hospital which is aggrieved by any action or failure to act under this part may file an appeal within 30 days to the Division of Hearings Officers pursuant to the requirements of G.L. c.6A, § 36, c.7, § 4H. The pendency of an appeal does not limit the Commission's right to undertake administrative review of a rate approved under this part.

Subpart O — Administrative Information Bulletin

Sec.

3.82 Purpose of Administrative Information Bulletins
3.83 Administrative Information Bulletins Issued under RSC Reg. 74-26

s 3.82 *Purpose of Administrative Information Bulletins* (numbering Rev. 9/30/76)

The Commission may, from time to time, issue administrative information bulletins to clarify its policy upon an understanding of substantive provisions of this part. In addition, the Commission may issue administrative information bulletins which specify the information and documentation necessary to implement this part or necessary for informed consideration of rate requests, rate adjustments, and rate review under this part.

s 3.83 *Administrative Information Bulletins Issued Under RSC Reg. 74-26* (Rev. 9/30/76)

The following Administrative Information Bulletins issued under RSC Reg. 74-26 are adopted under this subpart: 74-26-8; 74-26-9. These bulletins are to be applied as appropriate to the requirements of this part.

Subpart P — Rate Filings

Sec.

3.84 Rate Filings for Acute Care Hospitals
3.85 Rate Filings for Life Sustaining Drugs and Medications
3.86 Rate Filings for Chronic and Other Care Institutions
3.87 Rate Filings for Public Medical Institutions and Infirmaries
3.88
3.89

s 3.84 *Rate Filings for Acute Care Hospitals* (Rev. 9/30/76)

Inpatient, outpatient, and well-newborn rates for acute care hospitals determined and approved under this part shall be filed with the Secretary of the Commonwealth under this section.

s 3.85 *Rate Filings for Life Sustaining Drugs and Medications* (Added 9/30/76)

Rates for life sustaining drugs and medications determined and approved under this part shall be filed with the Secretary of the Commonwealth under this section.

s 3.86 *Rate Filings for Chronic and Other Care Institutions* (Rev. 9/30/76)

Inpatient and outpatient rate for chronic and other care institutions determined and approved under this part shall be filed with the Secretary of the Commonwealth under this section.

s 3.87 *Rate Filings for Public Medical Institutions and Infirmaries* (Rev. 9/30/76)

Inpatient and infirmary rates for public medical institutions and infirmaries determined and approved under this part shall be filed with the Secretary of the Commonwealth under this section.

Subpart Q — Hospital Statement for Reimbursement

Sec.

3.90 Hospital Statement for Reimbursement, RSC 100, RSC 401, RSC 401A

s 3.90 *Hospital Statement for Reimbursement, RSC 100, RSC 401, RSC 401A* (Rev. 9)

The RSC 100, RSC 401, RSC 401A, and schedules and instructions referenced in subpart E are incorporated in this section.

Supreme Court, U. S.
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OCT 2 1978
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In the
Supreme Court of the United States

OCTOBER TERM, 1978

No. 78-378

ST. ELIZABETH'S HOSPITAL OF BOSTON,
PETITIONER,
v.
STEPHEN M. WEINER, INDIVIDUALLY AND AS HE IS CHAIRMAN OF THE RATE SETTING COMMISSION IN THE EXECUTIVE OFFICE OF HUMAN SERVICES IN THE EXECUTIVE DEPARTMENT FOR THE COMMONWEALTH OF MASSACHUSETTS, ET AL.,
RESPONDENTS.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

Respondent's Brief in Opposition to Certiorari

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BATEMAN & SLADE, INC. BOSTON, MASSACHUSETTS.

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Statement of the Case

The petition seeks reversal of a decision of the First Circuit Court of Appeals upholding the Massachusetts scheme for reimbursing Medicaid providers for their services. The case involving petitioner, St. Elizabeth's Hospital, finds its ultimate

source in a civil action filed by another hospital, the Massachusetts General Hospital (MGH), on July 1, 1975. MGH sought declaratory and injunctive relief from Medicaid rate regulations promulgated by the Massachusetts Rate Setting Commission[1] (the Commission) and approved by the Secretary of Health, Education and Welfare[2] (the Secretary) pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1336-1396i, particularly 42 U.S.C. § 1396a(a)(13)(D). MGH's grounds for attack were that (1) the state regulations violated federal law, 42 U.S.C. § 1396a(a)(13)(D), and regulations promulgated thereunder, 45 C.F.R. § 250.30(a)(2) [recodified as 45 C.F.R. § 450.30(a)(2)], and (2) promulgation of the state regulations violated various constitutional provisions, including Art. I, § 10, cl. 1 (the Impairment of Contracts Clause), and the Due Process and Equal Protection Clauses of the Fourteenth Amendment. The state defendants filed a motion to dismiss the action on March 22, 1976, asserting principally that (a) the state regulations were consistent with federal law, as evidenced *inter alia* by the Secretary of HEW's approval of the regulations under a process mandated by Congress in its 1972 Amendments to Title XIX, and (b) the plaintiff's constitutional claims were insubstantial.[3]

On April 15, 1976, St. Elizabeth's Hospital of Boston (St. Elizabeth's) filed a motion to intervene as a party plaintiff. Along with this motion to intervene St. Elizabeth's filed its complaint as an intervening party plaintiff, restating verbatim the claims of MGH in the case-in-chief.

[1] The members of the Rate Setting Commission are the principal state defendants in this action. Additionally, the Governor, the Secretary of the Executive Office of Human Services, and the Commissioner of the Department of Public Welfare were named as defendants.

[2] The Secretary of Health, Education and Welfare, currently Joseph A. Califano, is the sole federal defendant.

[3] The federal defendant filed a motion to dismiss on October 29, 1976.

After a hearing on April 16, 1976, the district court took the question of MGH's dismissal under advisement. Prior to any further court action, MGH submitted a motion for summary judgment on January 3, 1977, as did the state defendants on January 12, 1977. At the court hearing on the cross-motions for summary judgment concerning MGH, held January 24, 1977, the district court allowed St. Elizabeth's motion to intervene. Following this hearing, the district court, on February 4, 1977, granted summary judgment for defendants, finding that (a) there was no genuine issue of material fact, (b) the state regulations were consistent with federal law, and (c) MGH's constitutional claims lacked merit (Pet. App. 1a-5a).

Because St. Elizabeth's motion to intervene was not formally acted upon until late in the proceedings, the district court determined on May 16, 1977, that St. Elizabeth's was not bound by the February 4 order. Subsequently, St. Elizabeth's filed a motion for summary judgment together with its supporting affidavits and exhibits. On June 8, 1977, the state defendants filed a motion for summary judgment as to St. Elizabeth's. On June 23, 1977, the district court entered summary judgment against St. Elizabeth's, finding that "the plaintiff-intervenor's complaint raises no issues other than those already fully briefed, argued and decided by the court's order entered February 4, 1977" (Pet. App. 10a-11a). The court rejected St. Elizabeth's claims on the same grounds as it rejected the claims of MGH.

Both St. Elizabeth's and MGH appealed to the court of appeals. The circuit court affirmed, holding that the Massachusetts Medicaid plan (1) was consistent with Title XIX of the Social Security Act, (2) afforded Medicaid providers with adequate protection under the Due Process Clause and (3) did not violate the Equal Protection Clause or impair the hospitals' contract rights.

Reasons Why Certiorari Should Be Denied

I. CERTIORARI SHOULD BE DENIED BECAUSE THE COURT OF APPEALS, IN UPHOLDING THE VALIDITY OF THE MASSACHUSETTS STATEWIDE MEDICAID PLAN, CORRECTLY INTERPRETED AND APPLIED THIS COURT'S DECISIONS.

A. *Introduction*

This case is an unattractive candidate for Supreme Court review. The petitioner reveals no conflict among the circuit courts on the questions decided by the First Circuit Court of Appeals. The underlying issues have not provoked substantial controversy, and the circuit court in deciding the case did not depart in any manner from this Court's prior decisions. Indeed, St. Elizabeth's in the petition alleges no such departure.

Finally, the underlying record set forth by St. Elizabeth's in this case is a weak one. St. Elizabeth's was not the original plaintiff in this action. Rather, it entered the case near the final stages as an intervenor, and presented no materials or claims substantially different from the original plaintiff, Massachusetts General Hospital (MGH). The record will show that, throughout the trial and appellate proceedings, the petitioner's choice of litigation strategy and substantive arguments simply replicated those of MGH.[4] Focusing, therefore, on St. Elizabeth's part of the litigation, the record is slender and wholly inadequate to permit adequate inquiry into the legality of Massachusetts' Medicaid reimbursement system.

[4] Notably, MGH, after expending the primary efforts in the litigation, chose not to seek certiorari.

B. *The Circuit Court, Acting in Harmony with this Court's Decisions, Deferred to the Judgment of the Secretary of Health, Education and Welfare in Assessing the Reasonableness of the Massachusetts State Plan.*

The Medicaid program authorized under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.*, reflects a cooperative federal-state effort to render medical assistance to needy families with dependent children as well as to certain aged, blind, or otherwise disabled individuals. In order to participate in Medicaid a state must submit a state plan to the Secretary of Health, Education and Welfare (Secretary) detailing the fulfillment of federal conditions set forth in Title XIX and regulations promulgated thereunder. If the Secretary determines that these conditions are met, he approves the plan, thereby enabling the state to obtain federal reimbursement for expeditures made to medical providers participating in Medicaid, in accordance with the state plan. (See Pet. App. 16a-17a.)

Prior to 1972, the Medicaid Act was read by both the Department of Health, Education and Welfare (HEW) and the federal courts to require states to reimbuse hospital providers the "costs actually incurred" by the provider in serving Medicaid patients (Pet. App. 17a). However, with the enactment of P.L. 92-603, states were no longer limited to this single approach to reimbursing hospitals for their services. Section 232 of P.L. 92-603 modified § 1396a(a)(13)(D) of the Medicaid Act to allow states to reimburse providers the "reasonable cost" of providing hospital services in accordance with "methods and standards . . . developed by the State and reviewed and approved by the Secretary" (Pet. 5). 42 U.S.C. § 1396a(a)(13)(D). The Secretary's regulations which implemented the Congressional Amendments provided that states may adopt the Title XVIII (Medicare) standard for reimbursing hospitals —

i.e., actual cost reimbursement — or may instead propose alternative plans for approval by the Secretary (Pet. App. 17a-18a). In accordance with these changes in law, Massachusetts submitted its prospective reimbursement plan to the Secretary for approval.[5] The Massachusetts plan was approved in December, 1973, by the Secretary, through his designee.

Essentially, petitioner argues that the circuit court erred in not substituting petitioner's concept of "reasonable cost" under 42 U.S.C. § 1396a(a)(13)(D) for that of the Secretary. The court of appeals refused to make this substitution and, consistent with the decisions of this Court, deferred to the judgment of the Secretary on this issue. The court found that the Massachusetts Medicaid plan was approved after careful and sensitive consideration by HEW (see Pet. App. 20a). Medicaid reimbursement is an area of federal activity in which the Congress has "entrust[ed] to the Secretary, . . . the primary responsibility for interpreting the statutory term [reasonable cost]." *Batterton* v. *Francis*, 432 U.S. 416, 425 (1977). In such circumstances the regulations of the Secretary carry with them legislative impact. They may not be set aside simply because a reviewing court might have interpreted the statute in a different manner. *Id.*, n. 9, and cases and authorities cited. Also, when Congress contemplates that an

[5]The state regulations set forth a reimbursement formula, using as a rate base the actual historical costs of a hospital for a particular past year, called a base year. 14 CHSR 3.20 (Pet. App. 101a). An inflation factor is then calculated reflecting the projected inflation rate for health care to be experienced by the class of providers from the end of the base year through the end of the rate year. The inflation factor is applied to all costs which are deemed subject to inflation. The total of these allowable costs, with certain other technical adjustments not material here, constitutes the figure from which a particular hospital's per diem reimbursement rate is calculated. The figure is divided by the number of "allowed inpatient days," 14 CHSR 3.32 (Pet. App. 103a), defined essentially as the actual inpatient days for the base year. The quotient constitutes the hospital's per diem rate of reimbursement.

agency's determination of the meaning of a statutory term will take place through specific administrative decisions, those decisions must be upheld so long as the agency's action is reasonable. 5 U.S.C. § 706(2)(A), (C); *see Citizens to Preserve Overton Park* v. *Volpe*, 401 U.S. 402, 416 (1971). Absent any showing of unreasonableness, the court was obligated to act as it did and to give deference to the Secretary's informed judgment. *See, e.g., American Telephone & Telegraph Co.* v. *United States*, 299 U.S. 232, 236-237 (1936); *Power Reactor Devel. Co.* v. *International Union of Electrical, Radio & Machine Workers*, 367 U.S. 396, 408 (1961); *Zemel* v. *Rusk*, 381 U.S. 1, 11 (1965); *Mourning* v. *Family Publications Service, Inc.*, 411 U.S. 356, 371-372 (1973).

In accordance with these cases the circuit court refused to set aside the Secretary's implementation of 42 U.S.C. § 1396a(a)(13)(D).

II. The Court Should Deny Review Because Petitioner has Failed to Exhaust its Administrative Remedies.

St. Elizabeth's advanced the argument in the district court that only actual cost reimbursement was permitted by 42 U.S.C. § 1396a(a)(13)(D). Its claim constituted a facial attack on the Medicaid reimbursement system. Such a claim raises questions of Congressional intent and administrative law, which were confronted and resolved by the courts below. By contrast, the other assertions by St. Elizabeth's (Pet. 11) regarding the inadequacy of the actual rates set by the Commission, as well as the hospital's efficiency of operation and quality of care, relate to the challenged regulations "as applied" in a particular context, raising discrete issues of adjudicative fact. While such issues might be relevant to a claim that the individual reimbursement rate for St. Elizabeth's was unreason-

ably low, and constituted confiscation, that claim was not made in this case. It is now far too late in this litigation for petitioner to veer away from its facial attack. Any claim that the regulations as applied to petitioner are invalid should first be brought within state machinery for administrative review.[6] *See* M.G.L. c. 6A, §§ 32-36 (West). If any hospital believes that it deserves a higher rate under the Medicaid system than it has been given, it should invoke the remedial processes provided by the regulations for that specific purpose. The record contains no indication that St. Elizabeth's ever sought to use available administrative processes before bringing its federal claim.

Thus, because petitioner's "as applied" claim was brought prematurely, it presents an inchoate record, lacking the concreteness essential for review in this Court. Petitioner's request for review should therefore be denied.

[6]If St. Elizabeth's believed that it deserved extraordinary rate treatment outside the boundaries of the prospective rate formula, it could have sought an administrative adjustment under the reimbursement regulations, with both administrative and judicial review available from an adverse determination. 14 CHSR 3.74-3.83 (Pet. App. 116a-122a); M.G.L. c. 6A, § 36; M.G.L. c. 30A, § 14. It is plain that under the state system facts tending to show a confiscatory result from application of the rates would compel rate adjustment.

Conclusion

For the reasons set forth above the Court should deny the petition for certiorari.

Respectfully submitted,

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No. 78-378

In the Supreme Court of the United States

OCTOBER TERM, 1978

ST. ELIZABETH'S HOSPITAL OF BOSTON, PETITIONER

v.

STEPHEN M. WEINER, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

MEMORANDUM FOR THE FEDERAL RESPONDENT IN OPPOSITION

WADE H. McCREE, JR.
Solicitor General
Department of Justice
Washington, D.C. 20530

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Petitioner contends that a plan adopted by the Massachusetts Rate Setting Commission—and approved by the Secretary of Health, Education, and Welfare—for the reimbursement of hospitals providing inpatient care under the Medicaid Act, 42 U.S.C. (and Supp. V) 1396 *et seq.*, does not reimburse it for "reasonable costs" of inpatient services, as required by 42 U.S.C. (Supp. V) 1396a(a)(13)(D), because the plan allegedly will not reimburse petitioner for its actual costs.

1. Under the Medicaid program the states reimburse providers of inpatient hospital services for "the reasonable cost of inpatient hospital services provided * * * as determined in accordance with methods and standards * * * which shall be developed by the State and reviewed

and approved by the Secretary * * *." 42 U.S.C. (Supp. V) 1396a(a)(13)(D). The states, in turn, are reimbursed by the federal government for a portion of the expenses incurred by the states. 42 U.S.C. 1396b.

Pursuant to Section 1396a, and in accordance with regulations promulgated by the Secretary, the Massachusetts Rate Setting Commission established a plan of prospective reimbursement that provides that all inpatient hospital care for Medicaid patients will be reimbursed by an all-inclusive per diem payment (Pet. App. 15a, 48a-69a). The state plan was approved by the Secretary in December 1973 (Pet. App. 16a). The plan includes a formula for calculating reimbursement by dividing a hospital's base year costs for all inpatients by its allowed number of base year inpatient days and adding an inflation factor (Pet. App. 16a, 50a-52a). The Commission's purpose was to establish "a method [that] will produce fair reasonable and adequate rates of payment that will promote increasing efficiencies in the operations of providers covered hereunder" (Pet. App. 49a).

2. Petitioner contends (Pet. 11) that the state plan does not provide reimbursement for "reasonable costs," and thus is contrary to 42 U.S.C. (Supp. V) 1396a(a)(13)(D), because petitioner allegedly "is not being reimbursed for its actual cost of furnishing quality and necessary inpatient care to [Medicaid patients] on an efficient and economic basis * * *."[1] Petitioner cites no authority for

[1]Although petitioner, in listing six questions allegedly presented (Pet. 3-4), states that contention in various ways, its basic argument (Pet. 10-13) is that under the statute the term "reasonable costs" is synonymous with "actual costs," whatever the actual costs may be. Petitioner does not attempt to show how its actual costs are reasonable and does not claim that the formula employed in the state plan precludes reimbursement of any category of reasonable costs.

While petitioner also presents as a question (Pet. 3) whether the state plan deprives petitioner of due process, it does not discuss that question, and any such contention would be insubstantial.

the proposition that the term "reasonable costs" is synonymous with "actual costs," and they are plainly not synonymous. Some actual costs may be unnecessary or wasteful, and hence not "reasonable." Indeed, as the court of appeals noted (Pet. App. 17a), Congress in 1972 amended Section 1396a(a)(13)(D) to make clear that states are not required to provide reimbursement on the basis of costs actually incurred.[2] Pub. L. No. 92-603, Sections 221(c)(5) and 232(a), 86 Stat. 1389, 1410. The Secretary's regulations have so construed the amended statute, since they permit states to adopt reimbursement plans that do not require reimbursement for actual costs (Pet. App. 17a-18a). The Secretary's construction of the statute is sufficiently reasonable "to be accepted by a reviewing court." *Zenith Radio Corp.* v. *United States*, No. 77-539 (June 21, 1978), slip op. 7; see also *Quern* v. *Mandley*, No. 77-1159 (June 6, 1978), slip op. 13.[3]

[2]Before its amendment, Section 1396a(a)(13)(D) merely required that state plans provide "payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services * * *." Under that provision, the Secretary had established standards that required reimbursement of actual costs (Pet. App. 17a). The statute was then amended to permit the states to select different standards for determining reasonable costs, and the Secretary's regulations were changed accordingly.

[3]Petitioner also argues (Pet. 10) that Section 222 of Pub. L. No. 92-603, 86 Stat. 1390, prohibits the Secretary from authorizing a state to adopt a prospective reimbursement system. Section 222, however, deals only with experiments and demonstration projects; it is not applicable here. The Secretary's authority to approve the alternate plan developed by the state in this case is based on 42 U.S.C. (Supp. V) 1396a(a)(13)(D) and 42 U.S.C. 1396a(b).

It is therefore respectfully submitted that the petition for a writ of certiorari should be denied.

WADE H. MCCREE, JR.
Solicitor General

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